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VA TELEHEALTH DURING AND BEYOND COVID–19: CHALLENGES AND OPPORTUNITIES IN RURAL AMERICA

HEARING

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COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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C O N T E N T S

WEDNESDAY, JULY 29, 2020

SENATORS

WITNESSES

APPENDIX

VA TELEHEALTH DURING AND BEYOND COVID–19: CHALLENGES AND OPPORTUNITIES IN RURAL AMERICA

WEDNESDAY, JULY 29, 2020

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2:03 p.m., in room SD-G50, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blackburn, Loeffler, Tester, Brown, Blumenthal, Hirono, Manchin and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman MORAN. Good afternoon, everyone. The committee will come to order.

We are here today in this hearing to discuss the Department of Veterans Affairs' use of telehealth as a modality to deliver care to veterans, especially those in parts of America that are rural, highly rural, or Tribal lands.

For my entire time that I have been a Member of Congress, I have been a proponent of telehealth as a way to deliver care to veterans and, in fact, to all patients, particularly those in Kansas, and especially those who live in rural areas. It has great potential.

Currently, we see these capabilities being utilized for an even greater share of veterans due to the pandemic of COVID–19.

COVID–19 has unexpectedly accelerated the process of expanding the VA's use of telehealth. In recent years, the VA had advanced its capabilities, but in the spring of this year, as the country and the VA prepared for the anticipated spread of the novel coronavirus, telehealth was often the only safe option to provide care.

The consolidation of resources at VA medical centers, postponing non-urgent in-person care, and restrictions placed on referrals to Community Care fueled a more widespread use of telemedicine.

As we continue to move toward a new normal, it is essential that the VA optimize the use of telehealth delivery where it works best, build on the lessons learned where it can be enhanced, and recognize the limits of its utilization.

Telehealth has great promise, and the unexpected expansion of telehealth has yielded great knowledge in the last few months. There are many times where it is practical for a veteran to see

their provider through VA Video Connect or even through just a conversation by phone. While this flexible and time-saving modality can be great in many ways, we know telehealth cannot entirely replace the need for face-to-face medical appointments. This is true as it relates to access to care in the community, and the VA must ensure the full implementation of the MISSION Act to increase access to Community Care is pursued.

The limitations of telehealth are also amplified for those living in rural America or Indian Country. VA Video Connect only works when you have a broadband connection at a certain speed. In many parts of our country, that reliable broadband service simply is not an option.

I am disappointed the VA chose not to participate in a recent listening session led by this committee with key stakeholders from across the medical community, telecommunications industry, VSOs, and other Federal agencies.

As of 2019, rural veterans make up approximately one-third of VHA enrollees and are, on the average, older than their urban veteran peers, tend to experience higher degrees of financial instability, and often live with a greater number of complex medical health needs and co-morbidities.

Many veterans in rural America and Indian Country live prohibitively far from VA facilities, which underscores both the need for innovative solutions on how to reach them and the importance of access to Community Care.

For rural and tribal veterans, the geographic barriers to VA care often go hand-in-hand with poor or nonexistent connectivity to broadband necessary for high-quality care via telehealth. I applaud the VA's outside-the-box thinking with regard to creative partnerships with the private sector and VSO community and the distribution of wireless devices to isolated veterans.

Additionally, I am interested in learning from our witnesses today, the progress the Department has made on forming agreements with telecommunications companies to provide subsidized short-term internet access to rural veterans. This was a provision I was proud to champion in the CARES Act in an effort to better serve the mental health care needs of rural veterans, especially during a time of social isolation during COVID–19, and look forward to hearing the progress the VA has made on this front.

It is also important to note, in addition to skyrocketing numbers of telehealth appointments, the VA has also been called on to fulfill its Fourth Mission across 46 States, including my home State of Kansas, as well as the District of Columbia, Puerto Rico, and the Navajo Nation.

As we look forward to both the near-term needs and long-term goals, the VA should make certain that the innovation of telehealth is utilized in the most efficient and appropriate way.

I look forward to hearing from all of our witnesses today on these challenges and opportunities and how we can work together to best leverage this modality to address long-standing access to care issues.

I understand that it has not been easy to adjust how the VA delivers care, especially at the rapid pace the COVID–19 pandemic

has required. I thank the VA for its work, and I thank them for being here today.

I want to yield now to my colleague, Senator Tester, who may be in the Indian Affairs Committee, where I am also supposed to be.

Senator Tester?

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. No. I have got a few minutes before either one of us have to get there, but I want to thank you, Mr. Chairman, for holding this hearing.

Chairman MORAN. Jon, we need greater volume.

Senator TESTER. Good God. That is always a problem, but I will work on it.

I want to thank you, Mr. Chairman.

Chairman MORAN. I am glad we raised the volume and allowed you to say that. I have never asked you to speak louder to me before.

Senator TESTER. Can you hear me now? I feel like an internet provider.

Chairman MORAN. I can hear you now.

Senator TESTER. You can hear me?

Chairman MORAN. Yes.

Senator TESTER. Good deal.

Well, I will say it for the third time. I want to thank you, Mr. Chairman, and I also want to thank our witnesses for being here today.

VA's recent efforts to expand telehealth options deserve a lot of praise. The Department has prioritized the health and well-being of its patients while working to keep its work force safe, and for that, you need to be commended.

However, a 75 percent increase in daily telehealth appointments as of May has not been without its challenges. Today's hearing is going to offer us an opportunity to take stock of where the VA is now and to discuss further steps that can be made to improve the care provided to veterans.

I want to hear directly from the VA, the Nation's largest integrated health care system, about the challenges that it is facing and what it is doing to address them.

In Montana, many vets, especially those in highly rural areas, are accustomed to virtual appointments, but we need to remember that not all veterans have access to smart telephone technology or reliable internet access. To address these technological shortcomings, I know the VA has conducted nearly 6 million more telephone appointments with veterans compared to the same period last year. What more can we be doing to make these visits more valuable for the patients and the providers, and how are providers coping with a change in practice? We need to ensure that VA staff is supported and have the tools that they need to adequately care for our vets.

We especially need management to work with employees in good faith to hear what the folks on the ground think about virtual or telephone care and what suggestions they have for improvement. That effort by the VA leadership will pay off greatly, particularly

when the health care system is experiencing increased demand and has a staff at risk of burning out as the coronavirus pandemic continues to rate.

As VA begins to reopen certain service lines in some facilities, it will be important to monitor the shift from telehealth appointments to in-person appointments. Many veterans may still feel uncomfortable seeing their providers face-to-face and will want to continue to utilize telehealth services. We need to make sure that that opportunity and the resources for that ongoing care are available.

And as hotspots and surges move from one location to another, VA's ability to expand and retract its telehealth capabilities will be critical. Therefore, it will be important to monitor whether the CARES Act funding is adequate to meet ongoing telehealth demand or if the successor COVID packages will need to include additional emergency funding to provide these services to veterans, and we will need a good accounting of where the appropriated funds are being spent in order to make informed decisions on a path forward.

I want to again thank the Chairman, and I want to thank the VA team for being here and being a part of this conversation. I look forward to this hearing.

Chairman MORAN. Senator Tester, thank you very much.

We are going to take a pause. So we will stand in recess just for a moment while we fix one of our own technical glitches so we can hear our witnesses who are appearing virtually.

[Recess.]

Chairman MORAN. So the committee will resume its work.

Thank you, Senator Tester, for your comments, and let me now introduce the witnesses from the Department of Veterans Affairs.

Dr. Kameron Matthews is the Assistant Under Secretary for Health for Community Care, Veterans Health Administration. Dr. Kevin Galpin is the executive director of Telehealth Services, Office of Connected Care, Veterans Health Administration; Dr. Thomas Klobucar, executive director, Office of Rural Health, Veterans Health Administration; and Mr. Eddie Pool, the executive director, Solutions Delivery, IT Operations and Services, Office of Information and Technology, Department of Veterans Affairs.

I thank you all for being here in person or virtually by connectivity, and we are grateful for your presence.

Dr. Matthews, I understand you are speaking for the group of VA witnesses today instead of individual Statements from each of our witnesses. As such, you are now recognized for 5 minutes to delivery your testimony.

STATEMENT OF KAMERON MATTHEWS; ACCOMPANIED BY KEVIN GALPIN, THOMAS KLOBUCAR AND EDDIE POOL

Dr. MATTHEWS. Thank you so much, sir.

Good afternoon, Chairman Moran, Ranking Member Tester, and distinguished members of the committee. I appreciate the opportunity to discuss VA's telehealth activities during the COVID–19 pandemic.

I am accompanied today by Dr. Kevin Galpin, Executive Director of Telehealth Services in the Offices of Connected Care; Dr. Thomas Klobucar, Executive Director of the Office of Rural Health; and

Mr. Eddie Pool, Executive Director, Office of Information and Technology.

This is a transformational time in U.S. health care, accelerated by the unprecedented challenge of the COVID–19 pandemic. VA is proud to be leading the response to COVID–19 beside our Federal partners. As a result of early proactive planning and the unmatched dedication and resilience of the VA work force, we are continuing to deliver excellence for the more than 9 million veterans who entrust us with their care.

In addition, we consider it a privilege to be the backstop to the Nation's health care system, serving veteran and civilian Americans in 46 States and the District of Columbia through our Fourth Mission, providing testing and supplies, and deploying more than 1,000 personnel in support of community facilities in areas of the Nation most severely affected by COVID–19.

VA has been open throughout the pandemic for all in-person care where clinical urgency rises above the risk of COVID–19, and we are now expanding in-person services at more than 100 sites.

We are grateful for the opportunity today to discuss a key area where VA's early and proactive commitment to innovation and health care delivery is paying significant dividends for those we serve; that is, telehealth. VA has long been recognized as a national leader in telehealth, and together with our strategic partners, we are rapidly advancing our vision to leverage telehealth to enhance the accessibility, capacity, quality, and experience of VA health care for veterans, their family members, and their caregivers anywhere in the country.

Continued expansion and deep integration of telehealth into clinical and technical operations is an essential element of our strategy. Telehealth can make it easy and enjoyable for veterans to partner with VA in optimizing health, and it can enhance the delivery of health care, enabling expert consultation, facilitating remote management of acute and chronic conditions, and enhancing coordination of care.

VA's early investment in virtual technologies, including our patient portal, My HealtheVet, provided a solid foundation for VA's agile and effective response to COVID–19. More than 60 percent of primary care and mental health providers had already used video telehealth prior to the pandemic, and VA delivered more than 2 million episodes of care through telehealth in Fiscal Year 2019, with approximately a third of the veterans served living in rural areas.

In a matter of weeks, at the beginning of this pandemic, that solid foundation enabled us to increase video telehealth delivery to veterans' homes by more than 1,000 percent. We have delivered more than 9 million additional virtual care interactions this year over last year, and the numbers continue to grow.

Achieving this progress required strong cross-functional partnerships. The Veterans Health Administration and the Office of Information and Technology have worked closely at all levels of the organization to address and stay ahead of the anticipated increase in demand for virtual care. Our IT colleagues strengthen and enhance the existing environment and are continuously monitoring and optimizing its performance. New and enhanced capabilities improve

telehealth visit performance and quality, and new scalable options expanded access, tripling the concurrent use of capacity of VA's video telehealth platform and enabling care delivery in a location of a veteran's choosing, such as at home.

Importantly, amidst the collective stress of this time, this capacity has allowed VA to provide over 1.5 million telemental health visits to more than 400,000 veterans so far this year. We want each veteran to know that VA is here for them, that we will meet them where they are, and that we believe in their resilience.

Expanded capacity has also advanced our other critical operations, including the tele-Intensive Care Unit program, which brings remote monitoring and consultation to augment care teams at the bedside of critically ill patients, and meaningfully, the benefits of added technical capacity are not just clinical. This also enables personal connectedness for veterans residing in community living centers or even hospitalized to connect with loved ones.

VA has continued to work with Tribes and Indian Health Service to develop standardized processes to ensure that veterans who require care among the various health care systems receive one coordinated approach in getting the services they need in the environment they choose. VA is planning a Tribal Consultation later this summer with the Tribes to deploy the approved plan.

VA appreciates the continued support of Congress regarding telehealth, including through the recent Coronavirus Aid Relief and Economic Security Act, which provided the supplemental funding needed for VA to invest in enhancing and expanding our systems and technology.

Recent legislation such as the MISSION Act, which authorized Anywhere to Anywhere telehealth, has also been pivotal to that advancement.

VA is committed to providing excellence for each veteran in our care, even and especially during these unprecedented times. We will continue to lead the way forward, and we are grateful for your continued support, as it is essential to provide care for veterans and their families.

This concludes my testimony. My colleagues and I are prepared to answer any questions that you may have.

Chairman MORAN. Doctor, thank you very, very much, and thank you to your colleagues for joining you.

I want to ask my question to Dr. Galpin, at least my initial question.

Could you detail for the committee the amount of CARES Act funding that has been spent to date on the total allocated for VA telehealth services?

And in addition to that, I have been exploring with the VA for several months now, the issue of the amount of money that was allocated to the VA in the CARES Act, which gave the VA authority to form agreements with telecommunication companies to provide short-term complimentary internet services to rural veterans, and generally, when I have those conversations—let me get an answer to your first question, and then I will follow-up with my second one related to that topic. So total amount of money spent compared to what was allocated under the CARES Act?

Dr. GALPIN.

[inaudible]—providers during the pandemic. So far, since March 1st and through July 15th, we have spent over $69 million on COVID-related requirements, of which $57.8 million came from the CARES Act funding.

We have used that to provide over 30,000 4G-connected iPads to veterans. For providers, we have bought 12,000 iPads, 24,000 webcams, 22,000 headsets, 10,000 speakers. We have expanded our help desk. That was a big challenge for us early on. It was just the amount of calls we were getting to the help desk as we expanded. We practically quadrupled the staff there.

We are funding some research to make sure we learn from this event, and we are expanding our telecritical care program with that funding as well. So, yes, that has been critical, but the number, I think you are looking for is just over $57 million so far.

Chairman MORAN. $57 million so far out of the amount that was appropriated which was what?

Dr. GALPIN. Ours was about $250 million. It included teleradiology as well, and a large chunk of that was for the telecritical expansion, which we are just about to undertake.

Chairman MORAN. Thank you very much.

The second part of this question is, when I have raised these topics before, I generally hear about iPads and Walmart. What I have not found an answer to is, How did the VA utilize that provision to create agreements with telecommunications company to provide services to rural veterans?

Dr. GALPIN. Yes, it is a great question. Fortunately, we have an office, a Strategic Partnership Office, and we have been working really for a while now to develop partnerships with organizations, with internet service providers or cellular providers to try and expand connectivity to veterans in rural communities, wherever they may be.

In telehealth, we realized when we were trying launching our Anywhere to Anywhere initiative that that was critical. We could build these fantastic programs, but if a veteran cannot receive it on the other end, it does not make a difference.

So we already have partnerships with T-Mobile, with Sprint which is owned by T-Mobile, with Verizon, with SafeLink by TracFone help support veterans. We are using VA Video Connect to make data.

As you know, as you mentioned, we have partnerships with Walmart, with veterans service organizations, and with Philips to develop our ATLAS sites in rural communities where veterans do not have internet access or therapeutic environment.

We have partnerships with Microsoft. Microsoft is helping us outline the areas in the country using both our data and FCC data when we have a population of veterans that do not have access to internet, and then they are going to help us go and identify additional partnerships to bring in Airband internet into those areas and help with digital scaling.

Following the CARES Act, we did actually get some companies from the committee who are interested in partnering with us. We have met with those. A lot of them are interested in helping out with the ATLAS program. I think that seems to be a real strong concept that people want to support.

The other area, which is great, is helping us co-promote the FCC Lifeline program. FCC Lifeline is a program a lot of veterans qualify for. We think it may be underutilized in the veteran population, and so we want to make sure veterans get that benefit. It is a subsidy of $9.25 a month for their internet or phone service, but if they are in Tribal or Native land, they can get up to $34.25 a month.

So we are trying to reach out to more partnerships. In the next couple weeks, we are going to be releasing an RFI, Request for Information, to go out publicly to look for other companies that want to partner with us. We feel there is probably more people out there than we have been able to identify so far that would like to help out the scenario.

I mean, it is amazing. Honestly, since we started the work with the Partnership Office, many companies are just absolutely ready to say yes when we talk about supporting veterans in the digital divide. It is an issue that people recognize really needs a broad coalition and a lot of support.

Chairman MORAN. Thank you, Dr. Galpin.

Let me ask you. I assume that if I ask my staff to delve deeper into the details of those partnerships, you and your team would be cooperative in providing us that information.

Dr. GALPIN. Yes. We would love to collaborate with you and your team on this. Again, this is a big issue and very important to us.

Chairman MORAN. Thank you for your efforts and your testimony.

Let me ask just a question that is worth more than the time I have. But, Dr. Matthews, can you explain how expanded telehealth services will impact access standards for community care?

Dr. MATTHEWS. Sure. This was——

Chairman MORAN. Go ahead.

Dr. MATTHEWS. Sorry.

Chairman MORAN. You anticipated my question.

Dr. MATTHEWS. Yes. This was actually a very early conversation, actually, that I had with Dr. Galpin and others in VA, how could—how should, actually, we approach the eligibility standards.

Currently, telehealth, unfortunately, does not impact them, and unfortunately, I mean, in the sense that it actually would take some regulatory change, so we could not do really any quick changes during the pandemic.

The idea is that telehealth is offered. If a veteran accepts that care, it will, of course, be coordinated, but otherwise it does not affect their eligibility. Eligibility is only determined by face-to-face services at this point.

Chairman MORAN. Thank you very much.

When you say at this point, you are suggesting there is a change coming?

Dr. MATTHEWS. There is always at least reconsideration. I think you would expect us to continue to improve upon how we provide access, and if telehealth—especially in specialty services is available and especially with our quality of care and when, of course, it is clinically appropriate. I think there is always going to be consideration that perhaps telehealth would be a major, meaning primary form of delivery. It could never replace face-to-face 100 per-

cent. That is in no way the concept there, but perhaps initial consultation, follow-up visits, and the like. So it would be actually as the MISSION Act promotes more of an integrated platform with face-to-face care in the community.

Chairman MORAN. Thank you. Senator Manchin?

SENATOR JOE MANCHIN

Senator MANCHIN. Thank you, Mr. Chairman. I appreciate it very much, and thank you, Doctor, for being here.

I have introduced the HOTSPOTS bill, which would expand our Government's ability to purchase and distribute internet-connected devices to libraries and low income in rural areas, and I encourage my Senate colleagues really to look into this. And, hopefully, we get this into the next package we are working on right now for the COVID relief package.

So many rural areas, especially rural Appalachia, does not have any connectivity whatsoever, but we have been able to hotwire, basically, a wireline into all rural libraries. This would allow—if a hotspot could be given to a veteran, they would be able to connect for telehealth. Right now, they cannot. All they are doing is audio health.

So my question, can you give me a sense of where all these—you spent $38.9 million, I am understanding, from the CARES Act on telehealth initiatives and equipment for both veterans and providers. You all reported distributing more than 46,000 iPads to veterans and providers for accessing and facilitating telehealth appointments and also reported an additional 22,000 iPads are on order.

So my question would be, Can you give me a sense of where all the devices are going? Are they all network-enabled? I want to make sure that, hopefully, my State of West Virginia is getting its fair share, and can you share a full report of where they have been distributed?

Can anybody speak to that?

Dr. GALPIN. I can speak to that. I do not have that data with me, but we have—we can get that breakdown for you after the hearing, if we can take that back for the record as to where they are distributed.

Senator MANCHIN. Can you also determine where the VA telehealth infrastructure resources are going and how you are helping veterans with high-speed internet access? That is what we are having problems with. There is no use to have an iPad if you have no connectivity. So I hope you are looking at——

Dr. GALPIN. Correct.

Senator MANCHIN [continuing]. the challenges that we have. Whether it is rural West Virginia, rural Arkansas, rural North Carolina, rural Kansas, wherever it may be, we have got problems, and to get quickly to help these people, HOTSPOTS would be the quickest way we can get them set up to something.

Dr. GALPIN. Yes. Let me provide some feedback on that. I think that was a question about what we are doing. So let me go through the broader list because you are absolutely right. This is a critical issue for us, and it is impossible for us to deliver telehealth services where there is not internet connectivity.

There was an FCC report that was released last year that said 2.2 million veteran households do not have fixed or mobile broadband internet.

Senator MANCHIN. First of all, if I can correct you on one thing. We have proven the FCC maps are totally incorrect. They are totally incorrect. That is why we are holding up some of their money until they get the maps corrected. So I hope you are not working off of their old maps because they have even agreed they are incorrect.

Dr. GALPIN. Well, I think irrespective of whether we are looking at the maps, we recognize that this is a problem. I mean, for the reason that you just described, when we talk to our providers and get their satisfaction surveys back—we just had one from one of our VISNs where they interviewed or got feedback from 1,600 providers, and one of the biggest challenges they face is the veteran not having the internet or the equipment on their end. And that is, again, why we launched an initiative to bridge the digital divide for veterans.

I can tell you it is something we cannot do alone. I mean, this is a huge issue, and the VA is not going to solve it alone. That is why we need cross-administration, collaboration with Congress, public-private sectors. There is a tremendous amount of work to do.

Senator MANCHIN. Well, I know you have all used solutions. One of your solutions was offering veterans to use store for telehealth options at places like Walmart, VFWs, American Legion halls through the ATLAS technology. The idea is that since a veteran does not have access to broadband at home, their local Walmart, VFW, American Legion would have better broadband.

While it sounds promising, you have only opened six ATLAS sites in five States, and unfortunately——

Dr. GALPIN. That is correct. So——

Senator MANCHIN. So what is the VA's plan to expand these telehealth sites?

Dr. GALPIN. So the ATLAS program, we think is very promising. Again, that is a public-private partnership that we have been working on.

What we have done—and going back to your library concept—we have created a scheduling package, a scheduling system so that we can identify if there is an ATLAS site near a veteran. So we can set up libraries via a set of sites, Walmart sites. Wherever we have a therapeutic environment, internet connection, and veterans in that area, we can establish this.

Now, we were beginning to open these sites, and we had a plan to get, I think, 11 prior to COVID. We did temporarily shut them down due to infectious disease concerns. We are now beginning to open them back up. The first one that opened was in Eureka, Montana. The Walmart sites are expected to open up by mid-August, and then we will continue on with the progression.

But we agree. I mean, this is a huge issue. We need to get the services out there, and there is a lot of veterans that either do not have the connectivity in their home or the home is not a therapeutic environment. And these type of ATLAS locations that can be in their community, if not their home, would serve both needs.

So this is a huge issue for us, and we are on the same page, as we need to solve it.

Senator MANCHIN. Well, let me just say as a State with a high percentage, one of the highest percentages of veterans, and a very patriotic State like all of our States are, but West Virginia has a very high percentage. If you want to try something and see if it works, try West Virginia because if it will work in our hills and mountains and valleys, it will work anywhere.

Dr. GALPIN. I appreciate that. Thank you.

Chairman MORAN. Senator Manchin, thank you.

I recognize Senator Boozman.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all for being here with your testimony.

I want to give you a pat on the back. I believe in Central Arkansas, the VA there, it is up 1,000 percent, and the Veterans Health Care System of the Ozarks, I think it is up approximately almost 4,400 percent in regard to their ability to do telemedicine. So they truly are leading in the area, and we appreciate your support as we go forward.

Senator Manchin was talking about the partnerships and things. Dr. Galpin, in the areas where the partnerships exist, even though there is not that many, are you seeing an increase in veterans using VHA to receive their health care? Is it working in the areas that are actually set up?

[No response.]

Senator BOOZMAN. Maybe our technology is not working.

Chairman MORAN. Dr. Galpin, are you there?

[No response.]

Chairman MORAN. Dr. Matthews?

Senator BOOZMAN. Yes.

Dr. MATTHEWS. I unfortunately cannot speak to numbers.

Dr. GALPIN. I do not know if anyone is having an issue, but we have not heard the questions or any of the comments in the last few minutes.

Mr. KLOBUCAR. I have not either.

Chairman MORAN. Can you hear now?

Mr. KLOBUCAR. I have not heard this time.

Chairman MORAN. Can you hear now?

Senator BOOZMAN. It is the story of my life.

Dr. GALPIN. Yes.

Mr. KLOBUCAR. We got it now. We can hear now.

Senator BOOZMAN. Okay. Good enough.

What I was saying was that, first of all, we have had a tremendous increase in Arkansas. We are very proud of that. They are doing a great job, and we just appreciate all that is being done in that area.

Senator Manchin talked about the partnerships. We would like to have more. In the areas, though, that we are actually doing the partnerships, what are the results? Are we seeing a significant increase in veterans using VHA as a result of that to get their health care?

Dr. GALPIN. I think I can address that, that question.

Senator BOOZMAN. Yes.

Dr. GALPIN. The partnerships for the past couple years have been focused on getting more video telehealth services out to veterans, and we had a strong program prior to this year. Last year, we did over 2.6 million episodes of telehealth care to over 900,000 veterans.

But what you have seen happen this year has been just incredible growth with the pandemic. So already this year—and as we all know, this year is not over yet—we have already done 3.6 million episodes of care to 1.2 million veterans. We have seen our use of Video Connect into the home, which is our platform that does deliver the video telehealth to the veteran. We have seen that grow by about 2,000 encounters a day to over, now touching, 32,000 encounters a day. It is over 1,000 percent increase.

Fortunately, with the public-private partnerships, we have been able to advertise. We have been able to purchase more equipment. So we are seeing the growth out there. We are seeing that veterans are adopting the technology.

We had some really nice feedback. The Veterans Experience Office just interviewed several veterans, about 43 in hour-long interviews. Overwhelmingly like telehealth, they prefer it over telephone because it makes them feel more connected to their providers and more comfortable with the visit.

So I think we are getting the word out there. The public-private partnerships have been critical in helping us communicate, to advertise, and again, getting the veterans some of the services that they otherwise might struggle to get.

Senator BOOZMAN. Right. So you are truly the industry leader in the sense of doing telehealth and doing a great job. Your numbers are way up.

I guess my next question—and you partly addressed it—but do we have enough data? Do we have the metrics? Not just the—you know, I like this on-the-phone type approach, but do we have the metrics on telehealth services to know that the quality of care and the outcomes of that care are better, worse, or equivalent to traditional in-person care?

Dr. GALPIN. Yes. There has been a good amount of research on this. So when you look at an area that I think is really important to us like telemental health, there is consistent research that shows that the quality of the telemental health visit is equivalent to care in person, and that crosses populations in the studies from civilians to veterans.

We also have regular feedback from our veterans. So we do veteran satisfaction surveys to see how their experience is, and that is a little different than the outcome.

But, in general, particularly pre-COVID, we saw very high satisfaction scores in telehealth: 96.9 percent in quality this year prior to March 1st, 87.9 in overall satisfaction, 87.3 in trust.

Now, we have seen some dips in some of those satisfaction scores since COVID in the 3 to 5 percent range, but we had some action to help out with that going forward that we are excited about.

In addition, we just, at one of our VISNs, interviewed providers and they asked about the quality there as well, and I think it was about 77.4 of the providers that do telehealth care was equivalent

or better quality than delivering care in person with masks, and 81 percent felt that the care was more efficient or equal to delivering care in person with masks. And that actually exceeded the efficiency, exceeded care via telephone.

So there are a lot of people that have studied this in the area—particularly in the area of mental health, and they do see that it is equivalent to traditional in-person care.

Senator BOOZMAN. Thank you, Dr. Galvin.

Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Boozman.

Senator Hirono?

SENATOR MAZIE HIRONO

Senator HIRONO. I was just listening to you, Dr. Galpin, talking about surveying veterans. Have you surveyed any veterans in Hawaii as to how they feel about telehealth?

Dr. GALPIN. I am fairly positive we have. We distribute surveys after our video visits. I do not have the breakdown here, but we can provide a breakdown. I think it is by VISN facility. So we can certainly get that information to you.

[PLEASE SEE PAGE 80 FOR RESPONSE]

Senator HIRONO. I would be curious to know, because I remember when the veterans are first given the option of doing remote telemedicine or some fashion of it. And I remember talking with veterans, albeit this was maybe a decade ago, and a number of them were quite resistant. And I think that what you are seeing, what you are telling me is that more of them are becoming used to this form of getting care, and that they consider it to be good, if not adequate.

Dr. GALPIN. Yes. Again, I will point to that Veterans Experience Office survey. That the veterans they interviewed, again, it was a small number, and I do not think that survey included anyone in Hawaii, but there was an overwhelming positive response to telehealth. Again, they preferred it over telephone because it made them feel more connected to the providers.

In general, I would say that this pandemic has been eye-opening to people, I think providers and veterans alike. I mean, we have had thousands of providers do this for the first time, thousands—hundreds of thousands of veterans do it for their first time, and I think people have recognized the value. And they appreciate the type of services you can get through the video modality.

Senator HIRONO. So Senator Joni Ernst and I really pushed for telehealth across State lines, so providers across State lines could provide those services, and that this provision was included in the MISSION Act.

This is for Dr. Matthews. In your testimony, you noted that this authority to go across State lines to provide services is pivotal for telehealth delivery for veterans.

So could you provide a little bit more detail on how this kind of authority has extended access to health care, and is there any particular type of health care that particularly benefits from telehealth? And how many providers across State lines have utilized this authority to provide services to people outside of the State in which they practice? Dr. Matthews?

Dr. MATTHEWS. Sure. I will definitely need to defer the majority of that question back to Dr. Galpin, but overall, just to note within the Community Care program, we had at the onset of the pandemic in similar timing with CMS, did extend telehealth coverage within our Community Care episodes of care. So while we are also organizing it at massive quantities within the VA, it is available through our Community Care network as well too, including urgent care.

But, Dr. Galpin, if you want to speak more about the provider concerns?

Dr. GALPIN. Yes, absolutely. And I will start out by just saying that the MISSION Act was absolutely critical for allowing us to move forward. That authority, which we call our Anywhere to Anywhere authority, allows us to feel comfortable delivering care on and off Federal property.

So when we look at VA Video Connect, irrespective of the State laws, our providers are able to deliver care into a veteran's home. So it allows us to make care more accessible. It allows us to take the care that was being delivered in a community outpatient clinic and do it at that Walmart site, take it to the veteran's home, help them get health care in the community.

The other big thing, though, and—oh, go ahead.

Senator HIRONO. Well, I wanted to know. Do you have a sense of how many providers are doing, providing this kind of care across State lines?

Dr. GALPIN. I do not have that number specifically.

Senator HIRONO. Are there participants?

Dr. GALPIN. I do not have that——

Senator HIRONO. Do you know whether there are thousands? If you have some idea? But if you do not, we move on because the fact is that it has expanded, telehealth accessibility.

So for Dr. Matthews again—I am sorry.

Did you want to add something else before I go on to the next question? If not, I am going to the next question.

One of the questions I have—I think I am running out of time. So if you do not mind. Citizens of the Freely Associated States—that would be the Republic of Marshall Islands, Federated States of Micronesia, Republic of Palau—they serve in the U.S. military, and do so and retire then like the U.S. citizens, yet the VA cannot provide direct services to these veterans because they are prohibited from doing so in foreign nations, that this includes prohibition against providing telehealth services.

So I would like to know. I mean, we need to do a statutory change in order to enable at least telehealth services to be provided to these citizens; is that correct? And have you——

Dr. GALPIN. Yes.

Senator HIRONO [continuing]. considered the feasibility of making that statutory change so at least telehealth services can be provided?

Dr. GALPIN. So I can address that. So, yes, it would require statutory change, starting with USC 1724. At present, we are prohibited from providing care internationally, and that is any type of care.

We have thousands of veterans who utilize the VA system, who live internationally. They come to a State or to a Territory to get care, but then they return home. And to those veterans, we cannot provide the same type of service that we provide to a veteran in a State. They have to come for care in a State. So it would require——

Senator HIRONO. Yes, I understand all that.

Dr. GALPIN [continuing]. statutory change.

Senator HIRONO. Would you support—would the VA support a statutory change to enable this kind of service to be provided?

Dr. GALPIN. I can tell you that we have certainly looked at it. I really cannot get ahead of the Department's opinion on it. So I think that is something we would have to take back and have a broader discussion with our leadership on.

Senator HIRONO. Please do that because I think it is what we owe the citizens of these countries to provide them some level of health care.

So one more question. I do not know what my time is, Mr. Chairman.

Senator BOOZMAN. [Presiding.] It is out.

Senator HIRONO. Well, there you go.

Do you mind if I just ask one more short question, Mr. Chairman?

Senator BOOZMAN. One really short one. Thank you. Go ahead.

Senator HIRONO. This is for Dr. Klobucar about connectivity in Pacific Islands, and while that has improved, many communities in the Pacific—while it has improved, many communities—sorry—in the Pacific Islands still lack sufficient connectivity for telehealth. What is the VA doing to improve internet connectivity for extremely remote and rural island locations like those in the Pacific Islands? Very briefly, are you doing anything to address that concern?

Mr. KLOBUCAR. Hi. I am hoping you can hear me.

As Dr. Galpin outlined before, we are seeking to work with community partners to make an attempt to do that and also investigating the possibility for local hotspots.

Senator HIRONO. Uh-huh.

Mr. KLOBUCAR. But that work is ongoing, and I do not know, Dr. Galpin, if you can elaborate any more on that.

Dr. GALPIN. I do not have too much to offer beyond what you said.

I think the key is that this really needs a broad leadership coalition. I do not think we can take this on and get to where we need to be for veterans. I think we need to collaborate with Congress, committee, across administration, other Federal agencies to really reach the end zone on this really critical issue.

So we would look forward to working with you all more on this, again, to get to where we need to be.

Senator HIRONO. Thank you very much.

Thanks, Mr. Chairman.

Senator BOOZMAN. Thank you, Senator Hirono.

Senator Cassidy?

SENATOR BILL CASSIDY

Senator CASSIDY. Thank you all.

Dr. Galpin, I am interested in the—we have spoken about outcomes. An earlier question was about the outcomes of telemental health, for example, versus those in person.

In some institutions, I know there has been a real problem with missed appointments, and I am interested whether compliance has actually improved or not. Is the reason for the noncompliance formally because someone just could not get there on time, but now they have taken care of that with telemental health, or is it just that their life is too disorganized to show up on time for anything? What have you all learned about that?

Dr. GALPIN. There is probably a good amount of studies on that, that I cannot quite today, but that is something we could find for you and bring back for the record.

I was just going to look up—because I know we did a study for our tablet program, and let me just provide some of the data here that I have in my notes. So tablet recipients experienced an increase of 1.94; for psychotherapy encounters, an increase of 1.05; medication management visits, an 18.5 percent increase; and their likelihood of receiving recommended mental health care necessary or continued care in the 20.24 percent increase in their missed opportunity rate in a 6-month period following the receipt of a tablet.

Senator CASSIDY. I am sorry. So there is an increased missed opportunity rate or a decreased missed opportunity rate?

Dr. GALPIN. Decrease. I am sorry. I misquoted my own reading here. Decrease, 20.24 percent decrease in their missed opportunity rate in that 6-month period.

Senator CASSIDY. Now, is there any——

Dr. GALPIN. So, you know, again, their——

Senator CASSIDY. It is pretty soon to tell, but I would be curious. Clearly, veteran suicide has been a risk, and we have had different strategies of how to reach people. The ability to reach online might be something which would augment a telephone hotline. Has there been any effort to look at that, or is it too soon? But any kind of implications regarding that issue?

Dr. GALPIN. Well, I think the one thing we can say is that to help improve and decrease veteran suicide, we need to get the care to the veteran, and so however the veteran wants to get care, I think we need to provide as many options as possible. So, you know, telehealth is a great option——

Senator CASSIDY. I accept that. I am just wondering if this is—if all—if all avenues of providing care are created equal, and I think that is what we are trying to figure out here is the—empirically, on some of our biggest public health issues, suicide, for example, among veterans, is this something which just sounds good, or is it really going to pan out? But it may just be that it is too soon.

Let me ask you as well, and this may be for you or Dr. Klobucar. We have obviously put a lot of money to expand the telehealth mental—the infrastructure. My hope is that that would decrease your unit cost of delivering care. It is a lot cheaper to have somebody in an office looking at a computer screen and going very efficiently one patient to the next than having a big waiting room and having all the attendant costs of clerks and aides, et cetera.

So is there any chance that this initial investment will result in cost reduction opportunities after next fiscal year?

Mr. KLOBUCAR. Hi. Yes. I cannot really speak to cost reduction, although we can find out what that looks like and get back with you with those data.

I think it is important to note and just to briefly refer back to what you said earlier that there are a number of programs that are Web-based programs that provide support for veterans online that are suffering from depression and post-traumatic stress disorder, and we have seen some significant uptake in that area. These are relatively new programs that the VA started in Fiscal Year 2019 or Fiscal Year 2018. So we expect those to continue to grow, particularly as our younger veterans grow older and our veteran population grows younger over time.

So we are making a significant effort with several online programs that we hope will have some advantage in helping those veterans with post-traumatic stress disorder.

As far as the numbers and the data and the cost per unit, I will definitely look into that for you and get back.

Senator CASSIDY. Maybe one last question. Are there any telehealth visits that are not appropriate? I am a physician. So, immediately, I think of the physical exam. You are quite limited what you can do for a physical exam, but are there any visits in which—somebody told me they want to do orthodontia by telehealth. How do you do orthodontia by telehealth?

So what is out there that we kind of learned, "Oh, it is better to have the people seen in person"?

Dr. GALPIN. The way we approach that—and I would say that every specialty could add a telehealth component now. Some specialties can do more of the care through telehealth, so telemental health. One of the reasons why it is so successful is they can do the vast majority of their care by that route. If you look at surgery, they can do pre-visit, post visit, obviously not the surgery itself.

So it is less about that we find a specialty or type of care that we cannot delivery through telehealth. It is more about what portion of that care can we deliver through telehealth.

Senator CASSIDY. And let me ask you——

Dr. GALPIN. So there is really no absolute——

Senator CASSIDY [continuing]. one more question.

Dr. GALPIN [continuing]. yes or no.

Senator CASSIDY. Doctor, one more thing, I am a gastroenterologist. I think I knew at one time, the VA required somebody to drive in to be consented. Even if they lived 100 miles away, they would have to drive in, get consented, return home, and then come back from the colonoscopy. It seemed very impractical, as anyone who has taken a colonoscopy prep can imagine.

So the question is, will VA regulations allow people to be consented for a procedure like a colonoscopy remotely by a telehealth visit as opposed to having to drive in?

Dr. GALPIN. I believe the answer is yes to that, but I need to check back and make sure I am being consistent with the regulation. But, yes, I believe the answer is yes to that.

Senator CASSIDY. Please let us know that.

[PLEASE SEE PAGE 81 FOR RESPONSE]

Okay. Thank you.
I yield back. Thank you, Mr. Chairman.
Senator BOOZMAN. Thank you.
Senator Blumenthal?

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman.
We have a vote, which I understand has been called. So I am going to try to be brief.
I know that the VA has provided some national statistics. Specifically, the telehealth video visits have increased by 1,132 percent since February, rising from about 11,000 to 138,700 appointments per week between February and June 2020, which is quite remarkable. Do you have statistics State by State specifically for Connecticut?
Dr. GALPIN. I do not have it with me for this hearing. I believe we can get those State by State.

[PLEASE SEE PAGE 84 FOR RESPONSE]

Senator BLUMENTHAL. Yes.
Dr. GALPIN. I believe we can.
Senator BLUMENTHAL. That would be great.
Can you tell me—maybe you will have to get back to me about this one too—how well Connecticut is doing, VA in Connecticut is doing in terms of telehealth?
Dr. GALPIN. Again, I do not have State-specific information with us today.
Senator BLUMENTHAL. Okay. Can you tell me what—I know that you answered the question about generally the need to form a coalition to get different groups together to bridge the digital divide. My guess is it affects veterans not only in rural areas, but throughout the country, because it affects our general population throughout the country. It affects school students, the homework gap.
I have been a major advocate of extending the Lifeline program, funding it more adequately. Commerce Committees had hearings on this issue.
Is the VA working with the FCC on this issue?
Dr. GALPIN. Yes. The Lifeline program is actually something that we are very excited about. We have talked to them. We have had FCC representatives at our meeting.
One of the things we are going to be doing in the next month is lodging a digital divide consult. So when a provider identifies that a veteran does not have technology or internet access, they can refer that veteran to a social worker.
And one of those tools a social worker will have in their tool belt is the Lifeline program. They are going to do an assessment, assuming the veteran is interested, to see whether the veteran qualifies and then help them get connected to those benefits. Again, it is $9.25 a month for veterans, and if you are on Native land or Tribal land, it is $34.25.
We would be interested in discussing what you are describing there as potentially an expansion of the benefits for veterans. That is something we would love to collaborate on and work together to discuss.

Senator BLUMENTHAL. Do you have an estimate as to what percentage of the veteran population lack connectivity? We hear about telehealth, but does the VA have an estimate on the percentage of its constituency?

Dr. GALPIN. Yes. So we have the data that the FCC provided last year in their report. In that report, they talked about 2.2 million veterans of the veteran population they had as 18 million not having access to fixed or mobile internet in their home. About 15 percent of veteran households do not subscribe to it, and there is about 364,000 veterans, about 0.2 percent of the veteran population that live in an area where they cannot get fixed or mobile broadband or fixed or mobile internet at sufficient speeds.

So it is a large population out there, which is why it is a big concern for us.

Senator BLUMENTHAL. And just going back to the line of questions that Senator Cassidy asked, specifically concerning veteran suicide, does telehealth offer potential means of reaching out, providing counseling that so far have not been used as well as they should?

Dr. GALPIN. Well, I think specifically telehealth is one of the ways that we can make mental health care more accessible. Again, it is a lot about can we get services out to the veterans who need them in a way that they want to receive them.

For some veterans, taking time off work is challenging, trying to find child care, to get to appointments, traveling the long distances. So telehealth is one of the ways that we can create quality visits where they can feel connected to their provider, but we can do it in an accessible way so that we are really lowering the activation energy threshold for a veteran to seek help.

There is also value in the sense that some veterans, they do not want to get care in their community. They might be concerned about getting care from the mental health provider that they are going to see in a store. This allows them to get care at a distance in a therapeutic environment.

So I think it is a huge way that we can get mental health care out to the veterans in a way that they want it. It does not mean it is going to work for everyone. Some people will prefer to come in, in person. Some people are going to prefer telephone, but again, we want to make sure all veterans have that option so they can get the care when they need it and they want it.

Senator BLUMENTHAL. Thank you. These topics are very, very important. My time has expired. Thank you for having this hearing, Mr. Chairman.

Senator BOOZMAN. Thank you, Senator Blumenthal.

Senator Blackburn?

[No response.]

Senator BOOZMAN. Senator Sinema?

[No response.]

Senator BOOZMAN. We have got a vote going on. So we may have people who have left and will come back.

Senator Loeffler?

SENATOR KELLY LOEFFLER

Senator LOEFFLER. Hi. Can you hear me?

Senator BOOZMAN. Yes, perfectly.

Senator LOEFFLER. Wonderful. Thank you so much, and thank you all for being here for this really important topic.

Obviously, the COVID–19 pandemic really demonstrated the value of telehealth across the VA throughout so many areas in the health care system and continues to, and it is vitally important we continue to ensure that veterans regain access to the full spectrum of in-person care. But, obviously, for now, the demand for telehealth will continue to remain high, and that is why it is imperative that residents, fellows, interns, and other VA health care trainees are given the chance to experience the needed ability to provide care via telehealth during their supervised training instead of having to learn on the job or in person.

And that is why I partnered with my Georgia colleague, Representative Buddy Carter, to introduce the VA MISSION Telehealth Clarification Act. It is a basic bill that allows supervised training to utilize telehealth technology throughout the delivery of care, and my version goes a step further by providing additional clarity on the types of qualified VA providers that can actually provide care through telehealth under the law. So it helps expand the VHA's capacity to provide much needed care through its existing work force. So I want to thank Congressman Carter for his partnership on that.

My question really relates to, Dr. Galpin, if you could comment on any of the steps that are being taken by VHA to ensure that providers are trained to provide care, effective care really, through telehealth as well as any limiting factors that we need to be aware of as we start to integrate telehealth more into our delivery of health care to our veterans to go forward.

Dr. GALPIN. I appreciate that question and certainly appreciate the bill that has been proposed.

Regarding your question about how we are working with providers to make them capable of doing telehealth, just to provide some context, last year as part of our Anywhere to Anywhere initiative, we set an objective that by the end of this year, 2020—this is pre-COVID—that all of our primary care clinicians and our mental health clinicians would be capable of offering video to the home.

Last year, we got to about 60 percent, and now we are at just about 90 percent in both categories. The goal is always to have all of our ambulatory care providers capable of delivering video to home by the end of the next year.

So what we are doing to that, we have national trainings the providers are taking. We are purchasing equipment for them. We are making sure their schedulers are capable of doing it, and so solely—well, not solely anymore, but we are moving toward, again, 100 percent capability there.

When you talk about some of the things that we need to do, we still have a lot of work to do on enhancing the experience. We want to make this as simple as possible for both veterans and providers. So we are taking feedback from both groups and making sure we are updating our processes, updating our software to make sure it works for everyone.

Some of the challenges, I think, you mentioned, what is hard, what needs to be done, this is an area where I think, again, we

need collaboration with Congress. We are still navigating a very complex legal environment, despite the MISSION Act. Even with the MISSION Act, Clarity Act, which would be outstanding in letting us use all of our clinical resources, all of our clinicians to participate in telehealth, there is still a challenging combination of Federal and State laws that limit us in providing comprehensive care to veterans through the modality or are confusing to our providers and so in some ways makes it challenging for them to participate in certain types of care where they would otherwise like to.

So I appreciate the question. I hope that I answered it and see if there is a followup.

Senator LOEFFLER. That is very helpful. Thank you, Doctor, and obviously, we would be interested to learn about some of the challenges as they relate to Federal laws that would limit your ability to deliver care. So thanks so much for everything.

I yield my time.

Senator MORAN. [Presiding.] If I understand where we are at, at the moment, it is Senator Sinema. Senator Sinema?

SENATOR KYRSTEN SINEMA

Senator SINEMA. Yes. Thank you, Mr. Chairman and Ranking Member Tester, for holding this hearing. And thank you to all of our witnesses for being here today.

Since the start of the pandemic, the CDC and health experts have emphasized the need to social distance, wear face coverings, and wash hands frequently to minimize the spread of the disease. Our daily lives look very different now than they did earlier this year.

Increased telework, distance learning, socializing, and telehealth have become more commonplace, but for many, access to broadband and devices still remains a challenge.

In Arizona, the VA health system covers a lot of rural areas, and access to telehealth can be a major resource for so many in these areas, but telehealth cannot work without access to broadband.

In addition to being a cosponsor of the Access to Broadband Act that was passed by the Commerce Committee a few months ago, I have repeatedly highlighted the importance of expanding broadband services, particularly during this pandemic.

So my first question is for Dr. Klobucar. According to the Department of Commerce, 22 percent of American households do not have access to the internet from home, and this issue disproportionately affects Indian Country where 53 percent of homes do not have access to broadband networks.

As VA expands telehealth services during the pandemic, what is the VA learning about broadband needs in rural and Tribal areas, and are barriers to access due to limitations of broadband a lack of devices or other critical infrastructure needs?

Mr. KLOBUCAR. Thank you for that question, Senator Sinema.

I think as Dr. Galpin indicated before, this is an area that is a constant challenge for us in VA, especially when we talk about Tribal areas. We have expanded telehealth services into some Tribal facilities across the country, but those opportunities present themselves locally as local VA medical centers look for solutions to deliver care to these Tribal communities.

Again, as Dr. Galpin said, this is something we cannot do alone. We do need the support of other agencies such as the U.S. Department of Agriculture Rural Utilities Service, such as the Federal Communications Commission, and others to try to reach into these Tribal lands where internet, broadband access is limited.

The President's Broadband Interagency Working Group that formed about 2 and-a-half years ago was an attempt to address some of those problems, and as a result, the NTIA has established some Web resources for local internet providers to help them access Federal funds, but certainly more is needed.

We are now with FEMA in Regions 1 and 2 to look for solutions in the region, and they are bringing together partnership with VA with USDA and with other national organizations to try to address some of these burning issues. This is an important issue for us, and it is something that we have been working with partners to try to address for a number of years. And we hope that the pandemic has made it increasingly evident that more needs to be done.

Senator SINEMA. Thank you.

Dr. Matthews, my office is hearing from veterans in Arizona who have been seen via telehealth appointment, and they have concerns that they did not get the same level of care they would have gotten in person. How is the VA addressing these concerns among veterans who might be hesitant or concerned about the care they are receiving virtually, and what processes do you have in place to collect feedback from veterans in these appointments so we can improve the process?

Dr. MATTHEWS. Thanks so much for that question. I will definitely defer to Dr. Galpin about the different processes the veterans can use to change their different platform.

We have instituted, even during this pandemic, a new Veterans Experience Survey focused on care associated with during this pandemic, and we are collecting that data now regularly. That survey just started July 10th, and we are getting information about their experience, both face-to-face care and telehealth, what their preferences would be for next visit and the like.

So we will continue to improve upon how veterans' experiences are actually reflected. A lot of the questions even get down to their technology concerns. Were they able to see their provider clearly? Could they hear them clearly? Do they feel that their privacy concerns were addressed?

So we are definitely taking the veteran experience into account, but, Dr. Galpin, if you want to go into some of the processes on how veterans can actually receive this care?

Dr. GALPIN. Yes. This is a really important area for us. Improving the veteran's experience, the family members, the caregiver's experience, that is part of our vision for telehealth in the VA.

We regularly collect—we have surveys that go out to veterans post their telehealth visit. So we can see the data, what the experience is. We can see that for providers as well, and so this is something that we take very seriously.

We are working with the Veterans Experience Office now. They were conducting interviews—I think I mentioned those before—that overwhelmingly veterans like telehealth, and they prefer it over a telephone. But we want to work with them to really map

out the entire experience. From the moment that someone talks to them about telehealth and when someone is offering them help with the equipment to ask them do they have the right internet, would they want to do a test call, if things do not work during the appointment, then obviously the experience in the level of care is not going to be good.

So our goal is to keep working on these areas, enhancing the processes, integrating the processes, and enhancing the technology so that we do meet expectations, but ultimately, we want this to be a choice for veterans.

We are in a really unusual time right now, but if this is a modality that does not work for an individual veteran, we want there to be an option for them to say, "I want in-person care. That works better for me," and that is really the right way to treat the individual, allow them to make their health care choices and to find their preferences.

Senator SINEMA. Thank you.

Mr. Chairman, I have additional questions I will submit for the record. Thank you. I yield back.

Senator MORAN. Thank you, Senator Sinema.

I think Senator Tillis is returning for an additional question, and I have a couple of additional questions. And then we will be close to wrapping up.

Let me make certain—that Senator Sinema's question caught my attention, and I want to make certain that the answer is that a veteran who does not feel comfortable, does not want to utilize telehealth is not in any way coerced to do so.

Dr. MATTHEWS. Correct, sir.

Senator MORAN. Thank you.

This would be Dr. Klobucar. Would you speak directly to the challenges the Department faces in providing virtual care to veterans in highly rural and frontier areas? What is the update that you would have on the VA Video Connect for a rural Native veteran project?

Mr. KLOBUCAR. Yes, sir. The Office of Rural Health's Veterans Rural health Resource Center in Salt Lake City has established a VA Video Connect project, and the goals behind this are to educate providers on delivering mental health care to Tribal nations, culturally sensitive mental health care, and also to deliver training for veterans who may wish to engage in that care.

This is an ongoing program. We have trained dozens of providers so far. It is a relatively new program, and it is designed to enhance the VA Video Connect effort as we expand out into more and more Tribal areas. There is ongoing expansion planned for next year and the following years, and we are seeing positive results already.

Senator MORAN. Thank you.

Dr. Galpin, I want to understand about the ATLAS telehealth pods. My understanding was they were closed at the start of the pandemic, and do you have an update on when those pods might be reopened?

Dr. GALPIN. Yes. The one in Eureka, Montana, has opened. The other ones, the Walmart sites, the plan is to open them in mid-August, and then we have another VSO site that we anticipate or we target for the end of September.

As you noted, they were closed down, and we were concerned about infection risk. We have worked with infection control, with Walmart, to make sure that we have new protocols in place. They will maybe feel a little bit different. Hopefully, people will feel safe going to them, and that we do want to then reopen them and expand. But that is the timeline.

Senator MORAN. Thank you.

This is not a filler question while we wait for Senator Tillis question, but I always give—at least I always attempt to give our witnesses an opportunity. Is there anything that you would like to make certain that I and the Committee hears, anything you would like to correct or wish that someone had have asked you that you would now like to answer?

Dr. MATTHEWS. Thank you for this opportunity, sir.

I think I just want to echo really what our executive in charge, Dr. Stone, almost builds into his message. He builds a video message every day during the pandemic. It is actually something that has caused a great deal of just positive energy throughout VHA, and one of his messages that is regularly shared is just one of great gratitude for our VA staff.

What it took for the administration to really respond to the pandemic, particularly in the March-April timeframe of converting to a very acute responsive mode, that took a great deal of energy. Even within my own office, the Office of Community Care is administrative completely. We are nowhere near the front line of actually taking care of patients.

My own deputy, three of my staff actually volunteer to go to the front line to assist with emergency management, and that is just one office. There were others as well.

So I would be remiss if I did not really recognize on the record just unbelievable commitment of the VA staff during this response.

Senator MORAN. Doctor, you are right and appropriate to do so, and I would be remiss if I did not agree with what you said and express gratitude on behalf of this committee and members of the U.S. Senate, but most importantly, our veterans for the efforts that were made to care for them during this time, which we wish would end sooner than it has. But we are grateful for those, and many of them are veterans themselves helping other veterans. So please express our gratitude for that circumstance.

Let me see if we are going to conclude this meeting, and I am ready to do so, unless you tell me otherwise. Done.

I thank our witnesses for being here, and thanks for bringing us some education and enlightenment. We have additional questions that would be submitted for the record. I would ask that the VA respond to those as soon as possible. The committee members should have those questions to the committee within 5 days.

With that, our hearing is concluded.

[Whereupon, at 3:17 p.m., the committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Senate Veterans' Affairs Committee Hearing
VA Telehealth During and Beyond COVID-19: Challenges and Opportunities in Rural America

Opening Statement of Chairman Jerry Moran
Wednesday, July 29, 2020

"Good afternoon, everyone. The committee will come to order.

"We are here today to discuss the VA's use of telehealth as a modality to deliver care to veterans, especially those in parts of America that are rural, highly rural, or tribal lands. My entire time in Congress, I have been a proponent of telehealth as an innovative way to deliver care to veterans and all Kansans, especially those who live in rural areas. Currently, we see these capabilities being utilized for an even greater share of veterans due to the continued risk of COVID-19.

"The COVID-19 pandemic has unexpectedly accelerated the process of expanding the VA's use of telehealth. In recent years the VA had advanced its capabilities, but in the spring of this year, as the country and the VA prepared for the anticipated spread of the novel coronavirus, telehealth was often the only safe option to provide care. The consolidation of resources at VA medical centers, postponing non-urgent in-person care, and restrictions placed on referrals for Community Care, fueled more widespread use of telemedicine.

"As we continue to move toward a new normal, it is essential that VA optimize the use of telehealth delivery where it works best, build on the lessons learned where it can be enhanced, and recognize the limits of its utilization.

"Telehealth has great promise, and the unexpected expansion of telehealth has yielded great knowledge in mere months. There are many times where it's practical for a veteran to see their provider through VA Video Connect, or even through a conversation on the phone. While this flexible and time-saving modality can be great in many ways, we know telehealth cannot entirely replace the need for face-to-face medical appointments. This is also true as it relates to access to care in the community and the VA must ensure the full implementation of the MISSION Act to increase access to Community Care.

"The limitations of telehealth are also amplified for those living in rural America or Indian Country. VA Video Connect only works when you have a broadband connection at a certain speed. In many parts of our country, that reliable broadband service simply isn't an option.

"I am disappointed the VA chose not to participate in a recent listening session led by this committee with key stakeholders from across the medical community, telecommunications industry, VSOs, and other federal agencies.

"As of 2019, rural veterans make up approximately one-third of VHA enrollees and are on average older than their urban veteran peers, tend to experience higher degrees of financial instability, and often live with a greater number of complex health needs and co-morbidities. Many veterans in rural America and Indian Country live prohibitively far from VA facilities, which underscores both the need for innovative solutions on how best to reach them and the importance of access to Community Care.

"For rural and tribal veterans, the geographic barriers to VA care often go hand-in-hand with poor or nonexistent connectivity to the broadband necessary for high-quality care via telehealth. I applaud the VA's outside-of-the-box thinking with regard to creative partnerships with the private sector and VSO community, and the distribution of wireless devices to isolated veterans.

"Additionally, I am interested in learning from our witnesses today the progress the Department has made on forming agreements with telecommunications companies to provide subsidized short-term internet access to rural

veterans. This was a provision I was proud to champion in the CARES Act, in an effort to better serve the mental health care needs of rural veterans, especially during a time of social isolation during COVID-19, and look forward to hearing the progress the VA has made on this front.

"It's also important to note, in addition to skyrocketing numbers of telehealth appointments, the VA has also been called on to fulfill its Fourth Mission across 46 states, including my home state of Kansas, as well as the District of Columbia, Puerto Rico, and the Navajo Nation. As we look forward to both the near term needs and longer term goals, the VA must make certain that the innovation of telehealth is utilized in the most effective way.

"I look forward to hearing from you all today on these challenges and opportunities, and how we can work together to best leverage this modality to address long-standing access to care issues. I understand that it has not been easy to adjust how the VA delivers care, especially at the rapid pace the COVID-19 pandemic has demanded.

"Thank you again for your work and for being here today."

STATEMENT OF
DR. KAMERON MATTHEWS
ASSISTANT UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)

SENATE COMMITTEE ON VETERANS' AFFAIRS
VA TELEHEALTH DURING AND BEYOND COVID-19: CHALLENGES AND OPPORTUNITIES IN RURAL AMERICA

July 29, 2020

Good Morning Chairman Moran, Ranking member Tester and distinguished Members of the committee. I appreciate the opportunity to discuss VA's telehealth activities during the coronavirus (COVID-19) pandemic. I am accompanied today by Dr. Kevin Galpin, Executive Director, Telehealth Services, Office of Connected Care; Dr. Thomas Klobucar, Executive Director, Office of Rural Health, VHA; and Mr. Eddie Pool, Executive Director, Office of Information and Technology (OIT).

Introduction

VA aims to enhance the accessibility, capacity, quality and experience of VA health care through the implementation of virtual care technologies that are effectively integrated into the lives of VA staff and the Veterans they serve.

VA has long been considered a national leader in telehealth, and expansion is an essential part of VA's strategy to increase Veteran access to health care. VA's early commitment to the innovative application of technology to engage patients remotely (e.g., through My Health**e**Vet - VA's personal health record; mobile and other connected applications; and an extensive and multi-faceted telehealth program) provided a solid foundation for an agile and effective response to the COVID-19 pandemic. The Department moved immediately to meet Veterans where they are and to ensure continued care delivery, including by increasing telehealth capacity to unprecedented levels.

In response to the pandemic, VHA worked closely with OIT to address and stay ahead of the anticipated increase in demand for virtual care. OIT stabilized the existing environment by monitoring and addressing potential issues; enhanced the capability, by improving telehealth visit performance and quality; and expanded access to telehealth by tripling the concurrent use capacity of VA's platform for clinical video telehealth known as VA Video Connect (VVC). VA has seen over a 1,200% increase in video visits from home going from 10,645 visits the first week of March to 139,854 visits the first full week of July. In May, VA recorded its first day with 2 million minutes of VVC visits. Now that this system has expanded to our VA Commercial Cloud (commonly known as Care2 Cloud), the Department continues to scale capacity to meet the exponential increase in demand for telehealth appointments. A key example of technology directly

supporting VA's business aim is the expansion of tele-intensive care unit (ICU) care, increasing virtual access to critical care specialists. Since onset of the pandemic, VA has deployed 244 tele-ICU carts across 91 VA Medical Centers. Along with the medical centers that already had tele-ICU technology, every VA facility with ICU beds is now equipped with 24/7 virtual access to critical care specialists.

VA appreciates the support of Congress regarding telehealth, especially through the recent Coronavirus Aid, Relief, and Economic Security Act, which provided the supplemental funding VA needed to invest in enhancing and expanding the systems and technology used to care for Veterans. Recent legislation such as section 151 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which authorized the practice of telemedicine by VA health care providers in any state regardless of the location of the provider or the Veteran, has also been pivotal to advance this mode of care delivery for Veterans. These actions have provided significant benefit, addressing what had been barriers to the continued rapid expansion of telehealth.

Population Covered

Telehealth capability is available to Veterans enrolled in VA health care. VA leverages technology to augment care for Veterans within VA health care facilities, in Veterans' homes, and anywhere there is access to an internet-connected computer, mobile phone or tablet. VA's telehealth reach was significant prior to the COVID-19 pandemic. VA's online patient portal, My Health**e**Vet, is accessible through VA's modernized web presence at www.VA.gov and had over 5 million registered users at the conclusion of 2019. VA's video telehealth program was utilized by more than 900,000 Veterans in 2019, 44% of whom lived in rural areas. Telehealth services are available at over a thousand VA sites of care, and care is delivered through video telehealth in more than fifty specialties that includes mental health care, primary care, specialty care and rehabilitation services.

Type of Services Provided

Telehealth can enhance the Veteran experience and the delivery of health care for Veterans in their homes and communities; at VA clinics; and as they access hospital-based and emergency services.

For Veterans at home, telehealth capabilities can help Veterans better manage their own health and enhance the accessibility of VA health care services irrespective of a Veteran's location in the country. Examples of VA's expansion in this type of Veteran engagement include delivery of care remotely through video visits through the VVC application; connecting with Veterans in their communities through the Advancing Telehealth Through Local Access Stations initiative; supporting Veterans with chronic conditions through the Remote Patient Monitoring-Home Telehealth Program; and providing Veterans with the technology they need to connect with VA through the

Veteran tablet loaner initiative. VA also continues to leverage web-based and mobile tools like My HealtheVet and VA's mobile apps to support Veterans as they self-manage their own health at home. Through these efforts, Veterans and their caregivers can access the information they need to help manage their health, and can access their providers, mental health specialists, nurses and other health care professionals using real time video or asynchronous communication from their homes or home communities. Veterans can also receive remote health care monitoring services, coordination of care, and tailored education about their chronic conditions.

VA is also continuing its expansion of clinic-based telehealth services. Initiatives in this category enable VA to provide more accessible services at clinic locations, build clinical capacity in underserved areas, and connect Veterans with the right clinical expert for their personal circumstance and condition. In addition, clinics are often the location where Veterans learn about services available to them at home. Examples of expansion in the clinic-based telehealth include the growth of regional clinical resource hubs for primary care, mental health, and specialty care; the development and expansion of targeted specialty telehealth initiatives such at tele-dermatology, tele-sleep medicine, and tele-oncology; and the expansion of a national expert consultation center model.

VA is also enhancing the quality of hospital and emergency services through the adoption of telehealth technologies. Technology can help provide Veterans timely access to the health care professional services they need in acute care and emergency situations, even when the specialty provider is not immediately available locally. Examples of this type of care include programs such as Tele-Stroke, which ensures Veterans presenting to participating VA emergency rooms can receive an urgent neurology assessment by a remote stroke specialist, who can provide evidence-based recommendations for stroke treatment to the in-person team. Another example is VA's tele-ICU (Intensive Care Unit) or tele-critical care program, which ensures critically ill Veterans in VA ICUs have urgent access to board certified intensivists and to experienced critical care nurses. One more example is the Telehealth Emergency Management Program, which provides remote clinical services following a declared emergency or disaster (e.g. hurricane, natural disaster, pandemic). During the COVID-19 pandemic, both tele-critical Care and telehealth emergency management have been an important part of VA's response.

Finally, in support of the expansion of telehealth in all settings (home, clinic, hospital), VA is investing in the necessary technology and supporting infrastructure as a foundation for these services. This investment includes the development and maintenance of mobile health and telehealth applications that are used by VA staff and Veterans alike to support care delivery at a distance, as well as VA's My HealtheVet patient portal. Other key investments include necessary training, implementation support, program office staffing, equipment maintenance and modernization, communications, evaluation/research, and provider and Veteran-facing help desk support.

VA Video Connect

VA Video Connect is VA's video telehealth platform that allows Veterans, their families and caregivers to meet virtually with their VA care teams on any computer, tablet or mobile device with an internet connection and web camera. VA Video Connect is one of the largest and most successful digital health platforms in the Nation and helps VA provide close to 30,000 virtual appointments to Veterans at home each day. Week-over-week telehealth video appointments to homes have increased by more than 1,200% since February 2020, increasing from approximately 10,700 appointments a week in early February to nearly 140,000 appointments a week in July. This rapid increase in video appointments was necessary to maintain safe clinical services in the setting of the COVID-19 pandemic and was made possible by the expansion and reengineering of select portions of VA's information technology infrastructure, as well as by rapid adoption of VA Video Connect by VA health care professionals.

To further increase Veteran connectedness, VA is taking strides to bridge the digital divide for Veterans who lack the technology or broadband internet connectivity required to participate in VA telehealth. More than 45,000 cellular-enabled tablets are currently distributed to Veterans across the country; and major wireless carriers such as Verizon, T-Mobile, SafeLink by Tracfone, and Sprint have partnered with VA to support Veterans' access to VA telehealth services. Further, VA is implementing a national digital divide consult. This consult will be used when Veterans could benefit from telehealth technologies but are identified as lacking access to a device or internet connection necessary to participate. Through this consult, VA intends to help Veterans leverage benefits available through VA, other Federal agencies, and the private sector to access what they need to connect remotely with VA services.

Specific Connected Care / Telehealth COVID-19 efforts

In an effort to expand video-to-the-home services for all Veterans, VA has engaged in the following: participated in webinar and social media outreach efforts; expanded telehealth capabilities to Veterans residing in community living centers and State Veterans Homes; used remote patient monitoring services to help monitor higher risk Veterans who need to be isolated or quarantined at home; leveraged video telehealth on inpatient hospital wards to enhance infection control among Veterans in isolation rooms; supported increased utilization of VA's online capabilities on VA.gov and My Health**e**Vet; launched specific text-messaging interventions to support Veterans who are concerned about COVID-19 and those who are isolating at home after possible exposure; extended the use of video telehealth in intensive care units to provide remote intensive care consultation at sites that may have limited intensive care specialty resources; and focused efforts of the Office of Veterans Access to Care and Office of Connected Care on maximizing telehealth into Specialty Care Services at our health care facilities to improve capacity and productivity moving forward.

Recent Trends

Health care is increasingly becoming consumer and technology driven. VA must continue to provide Veterans access to a modern technology-enhanced health care system. These efforts must include continued advancement of internet-enabled virtual care and telehealth technologies; integration of advanced analytics into these products; and incorporation of these solutions into VA's new electronic health record platform. VA continues to see high levels of Veteran engagement with connected technologies and anticipates continued acceleration of the use of these technologies, integrated into routine care delivery, as we lead the way forward following the COVID-19 pandemic.

The VA patient portal, My Health**e**Vet, leads the industry in customer satisfaction scores and in the percentages of patients who use the portal, has seen consistently increasing utilization, with a dramatic incline since the beginning of the COVID-19 pandemic. On the portal, VA processed over 9.37 million prescription refill requests and managed over 9.5 million secure messages between Veterans and their health care teams from January to May 2020. In the context of the COVID-19 pandemic, compared to the same period in 2019, this represents approximately 770,000 additional prescription refill requests and more than 2.11 million additional secure messages initiated by VA patients and their health care team.

Utilization of video telehealth services had also been increasing at a rapid rate prior to the pandemic and shifted to exponential growth during the pandemic. The use of VA telehealth services overall in 2019 increased more than 14% over 2018. The recently established Clinical Resource Hub Program, which currently provides primary care, mental health care, and is adding specialty care to support underserved locations is yet another example of expansion. Statistics from the program's early success shows that tele-mental health hubs served 257 spoke sites providing over 174,000 visits to more than 39,000 Veterans. Additionally, Video to the home or a non-VA location had also been increasing prior to the pandemic, with more than 99,000 Veterans engaging in a video health care session at home or at another offsite location in 2019. This represents a 246% growth over the prior year.

Support to Rural and Tribal Veterans

In support of the fourth mission, VA offered guidance and support for providers across the Nation to manage the COVID-19 public health emergency, particularly rural providers. VA developed a website specifically for these providers that included information on strong clinic practices and training for clinical staff and information for community providers who served Veterans. In addition, VA provided direct clinical support to Tribal Health Programs through the fourth mission.

VA has continued work in conjunction with Tribal representatives and the Indian Health Service to develop standardized processes for care coordination to ensure that Veterans who require care among the various health care systems receive one coordinated approach in getting the services they need in the environment they choose. VA is planning a tribal consultation on this plan later in the summer and then will work closely with the Tribal representatives to deploy the approved plan.

Approximately 8,000 Veterans received Compensated Work Therapy (CWT) services in June 2020, in comparison to 15,000 Veterans in June 2019. CWT Transitional Work was affected by restrictions imposed on outpatient services in many medical facilities; as outpatient services in medical facilities reopen, CWT participation rates are projected to return to and exceed previous levels of participation.

Conclusion

Veterans' care is our mission. We are committed to providing high-quality health care to all Veterans in our care, especially during these unprecedented times. VA is grateful for your continued support, as it is essential to providing this care for Veterans and their families. This concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.

VA Testimony Summary

- In response to COVID-19, VA Office of Information Technology (OIT) worked to rapidly stabilize the network, and expand access to telehealth by tripling the concurrent use of capacity of VA's platform for VA Video Connect, the Department's platform for clinical video telehealth.
- VA has seen a 1,200% increase in video visits from home; the first week in March the Department recorded 10,645 virtual visits, whereas VA had completed 139,854 virtual visits the first week in July 28, 2020.
- Section 151 of the *MISSION Act,* which authorized VA health care providers to deliver care across state lines has been pivotal to treat veterans during COVID-19.
- As of 2019, 900,000 veterans, 44% of which were classified as rural, utilized VA Video Connect.
- The Department has currently distributed more than 45,000 cellular-enabled tablets to veterans across the country, and wireless carriers such as Verizon, T-Mobile, SafeLink by Tracfone, and Sprint have partnered with VA to support these devices for VA telehealth services.
- VA is in the process of implementing a national digital divide consult in an effort to leverage benefits available through the VA, the federal government, and the private sector in order to advance care.
- The Department has utilized remote patient monitoring services to assist in observing veteran patients who are higher-risk.
- The Clinical Resource Hub Program that were recently established currently provides primary and mental health care to support underserved locations. Current data illustrates that the tele-mental hubs in particular served 257 spoke sites, which provided 174,000 virtual visits to approximately 39,000 veterans.
- VA has worked in conjunction with Tribal representatives and the Indian health Service (IHS) to develop standardized processes for care coordination to ensure veterans receiving care from the various health systems receive a coordinated approach.

CONGRESSIONAL TESTIMONY

STATEMENT FOR THE RECORD

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

PROVIDED TO THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

HEARING ON

"VA TELEHEALTH DURING AND BEYOND COVID-19: CHALLENGES AND OPPORTUNITIES IN RURAL AMERICA"

JULY 29, 2020

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
80 F Street, N.W., Washington, D.C. 20001 (202) 737-8700 www.afge.org

Chairman Moran, Ranking Member Tester, and Members of the Committee,
the American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on today's hearing titled "VA Telehealth During and Beyond COVID-19: Challenges and Opportunities in Rural America." AFGE represents more than 700,000 federal and District of Columbia government employees, 260,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees including many clinicians who provide telehealth and telemental health (telehealth) services to our nation's veterans. We hope that you find our recommendations for strengthening VA telehealth constructive and reasonable, and we stand ready to work with the Members of the Committee to make necessary and positive improvements to the VA's telehealth program.

AFGE strongly supports the expanded use of telehealth, when appropriate, to increase access to care, especially in rural areas. Daily registered nurse (RN) telehealth check-ins are an essential component of preventative care for veterans with chronic conditions such as diabetes, and heart conditions, as well as patients with COVID-19 who do not need to be hospitalized but need daily monitoring. Telehealth allows veterans who reside in more remote areas, as well as veterans whose health status makes it too risky to receive in person treatment during the current public health crisis, to receive the coordinated, integrated, specialized care that is only available through the VA's own health care system. AFGE commends Ranking Member Tester for his leadership during the coronavirus pandemic both for securing additional funds for

VA telehealth and call centers, and for urging the Department to expand telemental health services for our nation's veterans.

More generally, the Department's highly regarded telehealth program ensures that veterans continue to receive care without interruption during the ebbs and flows of public health emergencies that unexpectedly stretch needs for virtual care. Similarly, the VA's stellar telehealth program allows providers to respond quickly and seamlessly to changes in a veteran's health care status by allowing the proper integration of virtual care and in person care.

Secretary Wilkie recently announced that telehealth use is up 1000%. AFGE is concerned that the Department has not fully increased the number of clinical, information technology and support staff required to handle this enormous telehealth expansion. The shortages of RNs and other clinical staff working in telehealth that existed at many VA facilities prior to the pandemic have worsened significantly over the past several months as the number of video visits has skyrocketed. Outpatient virtual care of COVID patients has highlighted the need for additional telehealth clinicians. As the Department implements its plans to extend telehealth nursing to primary care PACT teams and other units, the need for additional telehealth nurses will increase. We urge the Committee to investigate the number of facilities that are currently not meeting the staffing standards in place for telehealth panels. Especially during the current crisis, the need for sufficient telehealth clinicians to provide the monitoring and preventative care that reduce hospitalizations cannot be overstated. More generally, we urge the Committee to also conduct oversight into the number of medical centers that are failing

to meet the Department's current goals for increasing the number of patient appointments handled virtually through the telehealth program.

The mental health professionals we represent at several VA medical facilities have had very positive experiences with telehealth expansions that were implemented during the pandemic. While some of them were initially skeptical about providing therapy remotely, they found it to be surprisingly effective. A psychologist conducting evening substance abuse group therapy sessions reported that attendance increased significantly when telehealth was implemented because it was so much easier for veterans to attend after work. Others commented that telehealth therapy is almost always just as effective, and in some cases, even more effective than in-person sessions. One provider remarked that patients with traumatic brain injury who missed some in person visits in the past now find it easier to keep track of their virtual appointments because the provider initiates the contact, placing less burden on the veteran. Involving military sexual trauma, there have been reports that patients are relieved to be able to receive treatment without coming to the facility.

Our members report that while some of the technological problems that hindered the delivery of telehealth at the beginning of the pandemic have abated, many others remain. While more veterans appear to have the equipment they need such as tablets for virtual appointments, there appears to be a significant shortage of government laptops that clinicians are required to use to communicate securely with their patients. Also, problems with the VA Video Connect (VVC) Program used for video visits need to be addressed; the system often breaks down. In the short term, some clinicians are using other video platforms instead, but a long-term fix is badly needed.

Similarly, the VA CITRIX Receiver software that is used to provide secure access is problematic. Clinicians have been allowed to temporarily bypass CITRIX and use other secure platforms instead, but they are concerned about management reinstating restrictions that require exclusive reliance on CITRIX going forward. We also received concerns regarding the scheduling software that telehealth staff must rely on to book appointments that often breaks down and causes double booking. AFGE urges additional Committee oversight over VA telehealth technology systems and would welcome the opportunity to share the concerns of the front-line employees who use these systems every day in order to identify the most effective technology and training solutions.

Our members are also concerned about the lack of information technology (IT) support especially at community-based outpatient clinics (CBOCs). The IT teams at the CBOCs must cover many different areas, making it difficult for clinicians to get the timely help they need when their systems fail. The CBOCs need a significant increase in the number of telehealth technicians. One facility expressed concern with the Department's inability to recruit and retain telehealth technicians because it fails to pay competitive wages. More generally, the Department's Office of Information and Technology (OIT) does not appear to have adequate resources dedicated specifically to the growing needs of its telehealth program.

There is also a need for uniform telehealth policies across VA facilities. Varying management policies have placed unnecessary restrictions on telehealth. For example, at one facility where veterans live in a domiciliary and other onsite residential facilities, management has required an arbitrary number of providers and patients to come to the

clinic to participate in telehealth sessions using clinic equipment instead of participating from the safety of their residences, resulting in unnecessary exposures for both patient and provider. The provider and support personnel are also exposed to health risks unnecessarily by having to enter the facility and then clean the rooms between sessions. Providers also expressed concern about the higher risks presented by the many aging VA facilities that lack modern and well-functioning air circulation systems.

These arbitrary policies requiring some providers to return to the campus and provide telehealth visits in clinic spaces are becoming more common as facilities begin to implement their own localized return-to-work policies. The lack of adequate national guidance at this phase of the pandemic is unfortunately creating the same inconsistencies and unintended consequences that we have seen related to personal protective equipment (PPE), testing, screening and leave policies.

AFGE strongly believes that the VA's growing and improving telemedicine capabilities can make the VA an attractive workplace for medical professionals, particularly during the COVID-19 pandemic and beyond. During this pandemic, telehealth has allowed employees with medical issues that put them at high risk of infection to continue to take care of veterans without interruption. This is especially valuable as so many VA employees continue to have concerns about adequate PPE, testing and other safety issues in the workplace.

The pandemic has made it necessary for the VA to consider additional ways to expand patient access through telehealth for safety reasons. Expanded access to telehealth has also yielded other short- and long-term benefits for VHA's complex

patient population. AFGE stands ready to work with the Committee to fully utilize all future opportunities to use telehealth capabilities to meet the needs of patients and the Department's dedicated workforce. We also hope the Department will be more receptive to working with AFGE and the front-line employees to address our recommendations for increased staffing, improved information technology and more commonsense policies that protect the health of patients and staff by maximizing the provision of remote services. We urge the Committee to encourage the Department to restore the valuable labor-management collaboration that enabled the VA to care for veterans during past national emergencies. Thank you.

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
"VA Telehealth During and Beyond COVID-19:
Challenges and Opportunities in Rural America" Hearing

July 29, 2020

Questions for the Record from Senator Jon Tester

VA Digital Health Strategy

Question 1: **As the Nation's largest integrated health care system and a leader in the use of telehealth for Veteran patient care, how is VA currently leveraging and integrating emerging digital health technologies, such as remote monitoring and digital therapeutics, to ensure that Veterans continue to have access to high qualitycare now and in the future?**

VA Response: The Veterans Health Administration (VHA) provides several tools to Veterans that support care delivery and care self-management. My HealtheVet, VA's patient portal and personal health record, allows Veterans to interact with VA to accomplish prescription refills, to message securely with their providers, to schedule and view appointments and to download, print and share copies of their medical records, including images.

Annie, VHA's text messaging application for Veterans self-management, allows Veterans to be assigned (or in some cases, to self-subscribe) to a variety of protocols such as ones for reporting on blood glucose or blood pressure, issuing reminders to take medications or to prepare for colonoscopies, avoiding Coronavirus and coping with the mental health effects of the pandemic.

VHA continues to innovate on ways to deliver care under the "Anywhere to Anywhere" telehealth initiative. Examples of newly developed products include Mental Health Checkup, an application that allows providers to assign mental health assessments to patients on a one-time or recurring basis. The patient has flexibility to take the assessment at a time and place convenient for them and then send the results back to VA for provider review.

VHA also is deploying My VA Images, an application that allows providers to request a patient send photos or short videos of skin findings, their gait, or their home environment as examples. My VA Images stores the submitted images in VHA's patient-generated health database along with selected data such as vital signs from other virtual care tools. A provider's ability to review patient-generated data will enable a more complete understanding of a patient's status and overall health.

The Remote Patient Monitoring-Home Telehealth program (RPM-HT) provides non-urgent/non-emergent care and case management for Veterans across VA. In FY 2020, VA provided over 140,000 Veterans with care through RPM-HT with an average daily census of 70,000. RPM-HT includes tracking and trending of vital signs, and other biometric data, and symptoms for review by an assigned Care Coordinator. The program uses a variety of technologies based on individual Veteran-specific needs. These technologies include the traditional hub device in the home (with and without video capability) as well as mobile technologies such as Interactive Voice Response, mobile app, and web-browser. The core of RPM-HT is the personal connection made with the assigned Care Coordinator who completes ongoing assessments, monitoring, patient education and case management of Veterans in collaboration with the Veteran's health care team. Use of RPM-HT helps to reduce clinical complications and the use of healthcare resources that health complications may consume as well as promotes healthy self-care behaviors. In early February 2020, VA developed plans rapidly to expand the RPM-HT program to assist with COVID-19 care. As of October 2020, the program enrolled over 10,000 Veterans for COVID-19 monitoring. This enrollment allows Veterans presenting to clinics or urgent care to be monitored at home thus promoting safe distancing for Veterans.

Question 2: **Additionally, does VA have a comprehensive digital health strategy, including vision and mission statements, detailed goals and objectives, and scorecards to track progress? If such a strategyis being drafted, please provide a planned completion date.**

VA Response: VA has had a Connected Care strategic plan in place for some time, pre-COVID-19. VA currently is developing a new five-year plan that will incorporate the exponential digital expansion VA achieved during the pandemic and the transformation trajectory VA is setting for the future (completion date pending).

Tele-Mental Health

Question 3: **What impact is the COVID-19 pandemic having on Veterans' access to mental health care? Specifically, are there enough telehealth options to address Veterans' needs, especially those in rural and highly rural areas? Furthermore, does VA have enough mental health care providers who are equipped to provide telehealth to Veterans?**

VA Response: Veterans' access to mental health care has been an underreported success story. In response to the pandemic, the Veterans Health Administration (VHA) rapidly shifted to offer predominantly virtual care in addition to in-person care for those who truly needed it. Throughout the pandemic, VHA has been able to maintain mental health workload levels similar to FY 2019 levels, thus ensuring access to care.

Prior to and throughout the pandemic, VHA offered a broad range of mental health services ranging from self-help and self-guided programs, outpatient care and acute inpatient psychiatric care. For example, outpatient treatments for depression and anxiety include medication management, as well as a broad array of evidence-based psychotherapies including Acceptance and Commitment Therapy for Depression, Cognitive Processing Therapy, Prolonged Exposure, Interpersonal Psychotherapy for Depression and Cognitive Behavioral Therapy for Depression, among others. To maintain Veteran and staff safety, VHA quickly adapted care to address the challenges of the COVID-19 pandemic. Even though, historically, VHA provides approximately 85% of VHA mental health services through face-to-face provision of care, in a very rapid shift and ramp up period VHA provided approximately 80% of VHA mental health care via virtual modalities (telephone and video).

In terms of data, prior to the pandemic, approximately 27,000 in-home video encounters took place with Veterans each month. By the end of the fiscal year, that number climbed to 395,000 visits in September alone.

In terms of the number of mental health providers equipped to deliver telehealth, it was a strategic goal already for VHA to build capacity and infrastructure and in many ways VHA led the Nation, including the private sector in delivery of virtual mental health care. VHA accelerated the goals to deploy telehealth capability with the advent of the pandemic.

At the present time, nearly all VA outpatient mental health providers are telehealth capable and 95% completed at least one telehealth visit to a Veteran's home or preferred location.

To increase ease of appointment engagement, VHA moved quickly to ensure all facilities with information technology capacity made Online Scheduling Requests available for Veterans.

In addition to telehealth and virtual care, VHA also rolled out several self-help tools. At the start of the pandemic, VHA quickly developed the self-help app, COVID Coach, for addressing pandemic-related mental health symptoms. To date, over 135,000 downloads have been completed. VHA maintains a dashboard for population management which identifies all Veterans with a new diagnosis of depression. Use of the dashboard by VHA providers to ensure critical medication coverage during the pandemic doubled. To address potential increases in anxiety associated with COVID-19 screening and results, VHA quickly modified additional population management dashboards for high-risk patient management.

Several initiatives focus specifically on rural and highly rural areas. For example, Clinical Resource Hubs in each Veterans Integrated Service Network (VISN) provide mental health staffing and service gap coverage for underserved spoke sites across the

country, with an emphasis on rural areas. For Veterans living in areas with limited broadband, the Accessing Telehealth through Local Area Stations (ATLAS) initiative offers Veterans the opportunity to receive care by video in private spaces at five Walmart and two Veteran Service Organization locations equipped with telehealth equipment and high-speed internet. For Veterans lacking access to a device or adequate internet connection, VA distributed thousands of 4G-enabled loaned tablets during its COVID-19 response and recently implemented the Digital Divide Consult offering Veterans increased support for tablets and internet connectivity. VA continues its partnership with the Microsoft "Airband Initiative," which leverages TV white space for broadband connectivity and teaches digital skills to expand rural internet access.

Question 4: **What impact is the pandemic having on the handoffs from the Veterans Crisis Line to the local VASuicide Prevention Coordinators? Specifically, how is VA ensuring Veterans still have that warm hand-off to care, even if it is to virtual care**?

VA Response: The Veterans Crisis Line (VCL) consult process allows for electronic submission of the consult to the appropriate Suicide Prevention Coordinator (SPC) team at the immediate conclusion of the VCL call. This process remained active and without interruption during the pandemic. SPC data for consult closure remained steady for the past three years, with first documented action occurring within one business day on 93% of consults.

If a Veteran who contacts the VCL needs same day care at a VA facility either in person or virtually, but does not require immediate police or emergency personnel intervention, the VCL initiates a Facility Transport Plan (FTP). An FTP is a collaborative plan developed by a VCL Responder and Veteran so the Veteran can present to a facility with staff aware and ready to provide care. The VCL Responder works with the Veteran to ensure a detailed and safe plan is in place for transportation to the same day appointment, and the VCL team follows up with the receiving facility to ensure the Veteran has arrived and will take necessary action to ensure safety if the Veteran has not arrived. All Veterans presenting to a VA emergency department with suicidal ideation or concerns are clinically assessed and appropriate care is provided which may include immediate hospitalization or outpatient follow-up.

VA Telehealth Status

Question 5: **Please describe how VA has used the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding for increased telehealth services during the pandemic. Specifically, how much has VA spent in total on telehealth from VHA medical services and VA information technology accounts from March through July?**

VA Response: The attached document includes the obligations and expenses from the Information Technology appropriation for telehealth.

	FY20 Pre-COVID	FY20 Post-COVID
Core Pexip Video Conf. Platform		
Pexip Conferencing App. Licenses	$ 1,427,482.00	$ 1,427,482.00
Care2 Cloud Costs	0	$257,859.31
Care - On Premise Costs	$ 540,999.26	$ 903,800.00
Server Replacement-Refresh	$ 282,145.39	$ 516,700.00
SSL Certificates	$117,044	$ 127,400.00
Power	$ 37,131.58	$ 68,000.00
NetApp Hardware Maint.	$ 104,678.29	$ 191,700.00
Vyopta Server	$ 328,740.00	$ 328,740.00
Subtotal	**$ 2,297,221.26**	**$ 2,917,881.31**
24/7 Pexip Support	0	
Total Pexip Platform Costs	**$ 2,297,221.26**	**$ 2,917,881.31**
Telehealth Monitoring		
Monitoring for 17 Telehealth of 115 COVID-19 Critical Apps	$ 1,247,169.00	$ 3,028,839.00
APM licensing	$ 52,500.00	$ 127,500.00
APM hosting	$ 10,500.00	$ 25,500.00
Personnel: instrument and dashboard	$ 904,169.00	$ 2,195,839.00
Personnel: event management	$ 280,000.00	$ 680,000.00
Total Monitoring Costs	$ 1,247,169.00	$ 3,028,839.00
Telehealth Total Costs	**$ 3,544,390.26**	**$ 5,946,720.31**

Pre-COVID vs. Post-COVID Costs	$ 2,402,330.04
% Increase in cost	68%
% Increase in demand	1260%
COVID-19 Critical Applications - Telehealth related	17
Pre-COVID-19 Telehealth related Applications monitored	7
Number of Telehealth Servers pre COVID	83
Number of Telehealth Servers post COVID	152
See Care Costs Tab - current 152 servers	
Added 69 servers for COVID-19 expansion in Care	

The following table lists CARES Act expenditures totaling $57.3 million used to expand the telehealth workload precipitated by the COVID-19 pandemic from March through July 2020. These items include clinical support and peripherals, provider training, 24/7 help desk support and expansion, additional application licenses and application design development and implementation. VA used the expenditures to expand telehealth service in alignment with VA priorities for providing high quality health care to our Veterans.

FY 2020 COVID-19 Obligations/Expenses (0160C2 Funds)	Transact Date	COVID/CFO Funded
COVID-19 VVC **Provider** Equipment	3/12/20	1,298,359.50
COVID-19 **Patient** IPAD Tablet	3/12/20	1,967,794.00
COVID-19 DigiCert SSL Certificates	3/16/20	64,020.00
COVID-19 Implementation of Staff Memorandum of Understanding (MOU)	3/18/20	20,851.00
COVID-19 National Telehealth Technology Help Desk (NTTHD) 24/7 Additional Staff	3/24/20	268,681.83
COVID-19 **Provider** iPad/Accessories	3/25/20	7,999,984.14
COVID-19 Telehealth Systems and Applications Release, Implementation and Deployment Support	4/07/20	546,012.00
COVID-19 **PROVIDER** Apple iPad	4/16/20	12,201,554.25
COVID-19 **PATIENT** Apple iPad	4/16/20	3,212,060.40
COVID-19 **PROVIDER** DELL 22 Monitor	4/16/20	804,000
COVID-19 National Telehealth Technology Help Desk (NTTHD)/ Mobile Applications Service Desk (MSD) Additional Staff (30) thru 8/31	4/23/20	2,383,837
COVID-19 SMS Gateway Services	4/20/20	77,184.00
COVID-19 Remediation Optional Tasks	4/24/20	5,834,499.32
COVID-19 DigiCert Additional SSL Certificates	4/16/20	80,902.50

COVID-19 Adobe Connect 2000 Additional Software	4/14/20	52,972.00
COVID-19 TCT OPTIONAL TASKS-CONTRACT # 203	5/22/20	538,985
COVID-19-iPad Pro Distribution @ MSD Help Desk	6/16/20	369,690.00
COVID-19 Memorandum of Understanding -Virtual Care -CORE Contract	6/18/20	800,000.00
COVID-19 Authority to Operate for Systems Applications: (Somnoware, AIP, CHAT)	6/20/20	500,000.00
COVID-19 PATIENT HOMELESS PRG IPHONES	6/26/20	8,065,868.00
COVID-19 Patient iPads (DALC)	6/29/20	7,636,970.00
COVID-19 Program Integration Program Support (PPS) Contract	7/8/20	633,500.00
COVID-19Connected Health Implementation Strategic Support Contract (CHISS)	7/8/20	895,000.00
Total (0160C2 Funds)		**56,252,724.94**
FY 2020 COVID-19 Obligations/Expenses (152C2 Funds)	**Transact Date**	**Cares ACT Funded**
COVID - 19 My HealtheVet (MHV) Program Management & Training Support	7/30/20	1,100,000
Total (152C2 Funds)		**1,100,000.00**
Total Cares Act Expenditures		**57,352,724.94**

Question 6: **According to VA, as of May, daily telehealth appointments are up 750 percent. How timely are those telehealth appointments on average? In addition, what is VA's capacity to provide telehealth services to Veterans? Furthermore, how much is the system being strained?**

VA Response: The following table shows the wait times by the type of care for VA's video to home teleconferencing system, VA Video Connect (VVC) and telehealth appointments from March 1, 2020 through October 31, 2020. The on-demand telehealth encounters happen immediately so the wait time is zero days and these on-demand appointments represent approximately 20.5% of all video visits.

	New Patient Wait Time (in days)	Established Patient Wait Time (in days)
Mental Health	8.9	2.1
Primary Care	9.4	3.2

Specialty Care and All Other	9.5	5.4

VVC can support approximately 17,500 concurrent video connections. Presently the system is operating at approximately 60-70% of peak capacity. The system is monitored to track demand and can add capacity if needed.

Question 7: **According to VA, as of February, telehealth services are available at 900 sites of care across the Nation. How many VA sites of care currently offer telehealth services to Veterans nationwide due to the pandemic? Specifically, how many VA sites in Montana are ready to provide telehealth to Veterans? In addition, what criteria does VA use to determine if a site is ready to offer telehealth services to Veterans?**

VA Response: At the end of FY 2020, 1,249 sites provided telehealth services to Veterans during the fiscal year. In Montana, 22 sites provide telehealth to Veterans.

Telehealth considers a site to be ready to offer telehealth if the site has the necessary equipment and internet to deliver the particular modality of telehealth (synchronous or asynchronous), there is space to provide patient privacy, the providers and/or other applicable staff have taken the necessary training to deliver telehealth and the administrative actions (e.g., clinics are set up to capture workload) are in place.

Community Care

Question 8: **VA provides care to Veterans through community providers when VA cannot provide the care needed. What impact is the pandemic having on community partners across the Nation to provide care to Veterans? Specifically, do community partners, especially those from Montana, have the capacity to see more Veterans during the pandemic?**

VA Response: On a national level, depending on the prevalence of COVID-19 in a specific community and local orders regarding opening services, some of our community partners are experiencing challenges when requested to appoint referrals. In October 2020, a new process requests the VAMCs to document in a specific manner their challenges with finding providers to deliver the requested care. This process will allow for a more standardized way of tracking and following up upon the specific types of care and provider gaps in the ability to appoint this care.

To provide alternatives to in-person care during the pandemic, VA expanded the use of telehealth technology in the community provider networks through the Community Care Network contract and collaborated with community providers nationwide to overcome barriers to delivering care. VA expanded telehealth reimbursement to be consistent with a Presidential Order effective March 6, 2020. Providers can bill for telehealth visits at

the same rate as in-person visits, initial nursing facility and discharge visits, home visits and therapy services.[1]

Montana currently has limited capacity to see Veterans in the community during the pandemic. Community Care Providers in Montana also are working through backlogs from the initial COVID-19 shutdown earlier this year. Montana Veterans experienced delays seeing a Community Care Provider due to this backlog and we are not seeing an increased capacity being offered to Veterans in lieu of other referrals and case mixes with private insurance.

Question 9: **How does VA ensure that community providers are taking all possible precautions to keep Veterans free from exposure to COVID-19?**

VA Response: VA's third-party administrators have contractual requirements to monitor patient safety, clinical quality assurance and quality improvement. VA requires providers to adhere to all Federal, State and local laws, which would include any COVID-19 safety precautions. VA uses Peer Review Committees and Potential Quality Incidents to review potential concerns with patient safety and clinical quality as well as addresses concerns raised by Veterans directly to VA.

Telephone Visits

Question 10: **According to VA, between January and June 2020, VA conducted 5.8 million additional telephone visits with Veterans compared to the same period in 2019. What steps is VA taking to ensure that Veterans are continuing to receive high-quality care via the telephone? How does a provider decide if a Veteran needs to switch from telephone appointments to telehealth or in-person visits?**

VAResponse: VA assesses appointment type, based on care need, for each episode of care. VA prioritizes appointments that do not require a physical assessment for alternative modalities (telephone). Before and throughout the early stages of the COVID-19 pandemic, VA recognized telephone care and offered it as a patient care option to address acute and routine healthcare needs. Although facilities adapted to deliver safe care both in-person and by video, VA implemented specialty care expansion, VA Video Connect (VVC) visits and telephone care to broaden available modalities for healthcare delivery.

Licensed health care providers make decisions around modality of care taking into consideration an individual Veteran's preferences for care delivery, his or her medical conditions and the health need being addressed during a visit.

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[1] "Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge," press release dated March 30, 2020: https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19.

Although providers identify modality of care in advance of the visit, it is sometimes not recognized until the telephone visit starts. Accordingly, VA health care providers can pivot between modalities of care during visits with Veterans. For example, if a provider decides while speaking to a Veteran over the telephone that the Veteran would benefit from a different form of care, the provider can switch the Veteran to an on-demand video visit immediately or make plans for the Veteran to present to the medical center for safe, in-person care delivery.

Telehealth Video Visits

Question 11: **According to VA, telehealth video visits increased 1,132% between February and June 2020. What is VA learning about Veterans' satisfaction with telehealth as well as their providers' satisfaction?**

VA Response: Based on survey results, Veterans generally have positive experiences with telehealth (Attachment 1).

Attachment 1
Data from FY 2020

	Overall Score % %4-5	Rural Score % %4-5
Telehealth - Aggregated Trust		
1. I trust Telehealth as part of my overall VA healthcare.	80.2	81.1
Telehealth Appointment Scheduling Survey		
1. I trust Telehealth as part of my overall VA healthcare.	77.4	77.3
2. I was given a choice between having my appointment in-person at a VA facility or through Telehealth.	53.5	57.9
3. I got my appointment on a date and time that worked for me.	89.6	89.3
4. When scheduling my appointment, I was treated with respect.	94.4	94.3
5. It was clear before my appointment what to expect.	83.6	82.9
Telehealth at the Clinic Appointment Survey		
1. I trust Telehealth as part of my overall VA healthcare.	86.1	86.1
2. After I checked in for my appointment, the clinic staff explained how the video Telehealth technology would work in a way that was easy to understand.	91.0	90.7
3. My provider explained things to me in a way that was easy to understand.	94.3	94.0
4. My provider listened to me during the appointment in a caring manner.	94.2	93.8
5. I was able to see the provider clearly by video.	94.2	95.1
6. I was able to hear the provider clearly by video.	91.1	92.5
7. The provider made me feel at ease by explaining every step they took during my appointment.	90.9	91.8
8. Overall, I am satisfied with the video Telehealth visit.	90.0	90.4
9. After my appointment, I was clear on what my next steps were.	90.7	90.8
10. Telehealth reduces the need to travel long distances in order to meet with my provider.	86.3	85.4
Telehealth at Home or Mobile Appointment Survey		
1. I trust Telehealth as part of my overall VA healthcare.	82.1	82.1
2. Connecting to my VA Video Connect appointment was easy.	86.2	85.0
3. The VA staff gave me information about connecting to my video Telehealth appointment.	88.7	89.7
4. My provider listened to me during the appointment in a caring manner.	95.3	95.6
5. My provider explained things to me in a way that was easy to understand.	94.8	94.9
6. After my appointment, I was clear about my next steps of care.	92.1	92.6
7. The provider made me feel at ease by explaining every step they took during my appointment.	92.0	92.5
8. Telehealth reduces the need to travel long distances in order to meet with my provider.	85.0	86.9
9. I was able to see the provider clearly by video.	85.6	84.8
10. I was able to hear the provider clearly by video.	84.9	84.0
11. Overall, I am satisfied with the video Telehealth visit.	83.9	83.2
Telehealth Store & Forward at the Clinic Appointment Survey		

1. I trust Telehealth as part of my overall VA healthcare.	85.7	84.7
2. I found the exam process to be an easy experience.	91.0	91.8
3. I felt comfortable during my exam appointment.	92.3	94.1
4. The Telehealth staff explained what would happen to me during the exam in terms I could understand.	90.1	91.1
5. At the end of my exam appointment, I was told when I could expect my results.	85.3	83.1
Telehealth Store & Forward at Home or Mobile Appointment Survey		
1. I trust Telehealth as part of my overall VA healthcare.	61.3	51.7
2. I found using my mobile device to capture my image or information to be an easy experience.	57.4	52.6
3. I felt comfortable with using my mobile device to capture my image or information.	60.0	54.5
4. The VA staff was helpful when showing me how to set up the tablet or app on my mobile device.	47.9	44.9
5. After submitting my image or information, it was clear to me when I would expect my results.	45.0	441
Telehealth Store & Forward Result Survey		
1. I trust Telehealth as part of my overall VA healthcare.	70.9	72.2
2. I received my exam results in a timely manner.	79.9	79.4
3. The VA provider told me my exam results in a caring manner.	78.3	78.4
4. The exam results were explained to me in terms I could understand.	78.2	77.9
5. When I needed a follow-up appointment, it was scheduled for me in a timely manner.	72.5	74.5
6. I felt clear on my next steps after seeing my exam results.	75.1	74.8
Home Telehealth Continuing Patient Survey		
1. I trust Home Telehealth program as part of my overall VA healthcare.	91.8	925
2. If I take my vitals, submitting them each day (i.e., blood sugar, blood pressure, weight, etc.) is a simple process.	89.0	89.0
3. I know that when I submit my responses to questions and vitals, my Care Coordinator will review them.	91.1	91.6
4. I feel safe knowing that my Care Coordinator is monitoring my health.	91.0	91.3
5. During phone calls, the care given by my Care Coordinator put me at ease.	89.5	90.2

In a survey of 1,607 telehealth providers, 77.4% felt the quality of video care is equivalent to or higher than in-person care with masks. Phone care received a lower score of 62.9%. In the same survey, 81.0% of providers felt the efficiency of video care is equivalent to or higher than in-person care with masks. Phone care received a lower score of 77.2%. Some telehealth challenges noted by providers in this survey included adequacy of patient internet connections, patient skills using their device and the telehealth platform and the need for more local technical support/training for patients.

Question 12: **Furthermore, according to VA, as of July 23, rural Veterans have made about 36% of all telehealth video visits during the pandemic. For some rural Veterans who may not have appropriate technology background, what steps is VA taking to enhance their experience during those initial telehealth video visits?**

VA Response: To support teaching Veterans the digital skills required to engage in video telehealth, VA has a national helpdesk to assist with test calls and technical troubleshooting. In addition, each VA facility is establishing their own test call program to ensure ease of access and timely support for video test calls ahead of a Veteran's first video visit. In support of these facility efforts, VA is developing a pilot program that will include student volunteers in the VA Video Connect (VVC) test call process.

VA also continues to expand its connected tablet program. Through this program, VA may loan a VA-issued iPad to Veterans without internet or technology so they can connect with VA using telehealth. To enhance the experience of this program, VA is implementing a device onboarding and education process for Veterans. When Veterans receive a VA device (e.g., tablet), VA will provide them with education on its use and functions. Additionally, VA will conduct a test call with the Veterans using the device to ensure they have the skills needed to connect to telehealth visits.

VA's ATLAS pilot intends to address the digital divide in rural and remote areas where fewer options for connectivity are available. At five Walmart locations and select Veteran Service Organizations, VA established private rooms with telehealth equipment and high-speed Internet for Veterans to securely connect to their VA care teams by telehealth.

VA is partnering with Microsoft to help expand internet access to select rural communities through their "Airband Initiative." The Airband Initiative leverages TV white space for broadband connectivity and offers free digital skilling classes.

Accessing Telehealth Through Local Area Stations (ATLAS)

Question 13: **Due to the pandemic, VA appropriately closed each of the current six ATLAS sites for clinical services. VA is starting to re-open these sites. Since late June, the ATLAS site in Eureka, Montana, resumed clinical services. How is VA balancing public health concerns with the re-opening plans for these sites?**

VA Response: All ATLAS sites suspended services in April 2020 during the onset of the COVID-19 pandemic. With our partners and support from our local VA sites, the ATLAS Program Team, in collaboration with the VHA's National Infectious Diseases Services, created COVID-19 infection and safety precautions and procedures. VA implemented them at each ATLAS site to keep patients and staff safe. Such procedures include extra hand hygiene, more frequent disinfection of surfaces and equipment with medical-grade wipes, use of face coverings and COVID-19 screening prior to an appointment. The ATLAS Program Team is monitoring the COVID-19 outbreak closely and will issue additional guidance if needed.

Question 14: **Is VA planning to conduct an evaluation on the effectiveness of current ATLAS sites to support Veterans' access to health care?**

VA Response: VA is conducting a partnered evaluation of ATLAS through the Quality Enhancement Research Initiative (QUERI) to examine qualitative and quantitative outcomes as well as Veteran satisfaction associated with the pilot. In addition, the VA is performing an evaluation of quality of care and experience specifically for care occurring in ATLAS spaces led by the VA Collaboration Evaluation Center Team and Veterans' Experience Office.

My HealtheVet

Question 15: **According to VA, from January to June 2020, My HealtheVet, VA's patient portal, processed more than 11.2 million prescription refill requests and managed more than 11.6 million secure messages between Veterans and their providers. As VA moves forward with the new Cerner Electronic Health Record (EHR) system at different sites nationwide, what is VA's plan to integrate My**

HealtheVet with the new EHR system so that Veterans engaging with the new EHR could have access also to My HealtheVet patient portal capabilities?

VA Response: On October 24, 2020, VA went live with the new electronic health record solution at the Mann-Grandstaff VAMC in Spokane, Washington. VA.gov and My HealtheVet have begun directing Veterans supported by Mann-Grandstaff VAMC to the My VA Health patient portal in place of My HealtheVet as part of Go-Live. Veterans at Mann-Grandstaff VAMC will receive the same patient portal capabilities widely supported in My HealtheVet, including scheduling and prescription refills.

VA will conduct a full analysis to determine the patient portal configuration that best supports the long-term needs of VA and ensures the continued strength of the Veteran experience while respecting taxpayers' dollars. VA will notify Congress once a decision is made. In the interim, the Office of Electronic Health Record Modernization, in coordination with the Contracting Officer, directed Cerner to not expend additional resources in support of an enterprise-wide portal deployment until after development of the long-term portal requirements.

Information Technology

Question 16: **According to VA, as of July 17, VA distributed more than 46,000 iPads to Veterans and providers for accessing and facilitating their telehealth appointments. How is VA determining which Veterans get iPads? In addition, what support does VA make available to Veterans and providers receiving those devices to become more comfortable with telehealth?**

VA Response: The newly rolled out Digital Divide Consult establishes eligibility criteria for Veterans to receive a VA-loaned device through the VA Connected Devices program, prioritizing a high-risk cohort of Veterans with demographics that include living over a 60 minute drive to a VA facility, having a mental health diagnosis and recent hospitalization, among other conditions. The consult enables front-line clinical teams to identify Veterans in need of a device or connectivity and is supported by facility social workers. The social workers assist potentially eligible Veterans with an application to the Federal Communication Commission's Lifeline program and/or order for a VA Connected Device.

The Office of Connected Care Helpdesk is available to assist providers and Veterans in setting up and troubleshooting their device, conducting test calls, etc. The iPads come with instructions to set up the iPad and how to receive additional support if required. Furthermore, VA is establishing a Connected Device Support program to provide a white glove experience to Veterans receiving VA-issued devices (i.e., iPads and iPhones). The Veteran will receive a call from a technician who will walk the Veteran through the entire set up of their device and ensure the Veteran feels comfortable using the device.

Question 17: **What cybersecurity measures is VA taking to safeguard Veterans' protected health information during their telehealth visits with providers? In addition, have there been any cybersecurity issues during the delivery of telehealth services to Veterans since the COVID-19 outbreak?**

VA Response: VA Video Connect (VVC) is designed with security and privacy controls to safeguard Veteran's protected health information during their telehealth visits. VVC sessions require a room number and PIN. The health care provider has "host controls" to lock and unlock the session to prevent/allow others from joining the meeting. Health care providers have full control over the session and have access to the patient participant list and events and the ability to mute/unmute another participant, disconnect a participant, disconnect all participants and transfer a patient participant to another session. VVC does not have a recording feature and does not allow Real Time Messaging Protocol (RTMP) streaming recording. After the health care provider disconnects from a session, the session will automatically disconnect patients.

VVC runs on the Pexip platform and benefits from Pexip's industry-standard encryption and security protocols to maintain privacy and security. Compliance and certifications of the Pexip solution include:

- GDPR (EU Regulation 2016/679) compliance;
- ISO/IEC 27001:2013 certification;
- U.S. Department of Defense (DoD) Joint Interoperability Test Command (JITC) certification;
- Federal Information Processing Standard (FIPS) Publication 140-2 compliance;
- Health Insurance Portability and Accountability Act (HIPAA) compliance; and
- SOC2/SSAE16 compliant data centers.[2]

Privacy and cybersecurity incidents have been exceedingly rare with the use of VA Video Connect. Four potential information security events have been brought to national attention and investigated since the beginning of COVID. One was related to a process error at one facility that has been corrected. None have been found related to the VVC application itself. There was an additional incident involving misuse of a VA data plan distributed with a VA device. This incident is still under investigation.

[2] Security and Privacy with Pexip website: https://www.pexip.com/security/security-data-protection.

The VA Veteran Patient Video Tablets (PVT) and VA Veteran Patient Video Smart Phones (PVSP) are centrally managed and secured using a Mobile Device Management (MDM) system which manages mobile devices throughout their entire lifecycle, from deployment to retirement. The MDM controls all aspects of the assets, managing applications, content, and settings, thus keeping devices and data safe and secure. Each device is password protected, encrypted, and is reviewed and approved by VA Security.

Questions for the Record from Senator John Boozman

Question 1: **I understand the VA has temporarily allowed telehealth to substitute for certain required face-to-face visits, such as an initial consultation and periodic check-ins, for those patients who need access to diabetes treatment, such as continuous glucose monitoring (CGM) devices. This approach is in-line with steps other government payors, like Medicare, have taken. However, Medicare is also exercising enforcement discretion on the remaining coverage criteria that currently restrict beneficiary access to CGM to facilitate safe and appropriate patient care during the pandemic. Is the VA planning to take a similar step? If so, when can we expect an update on the status? If not, why not?**

VA Response: Yes, the VA will follow the Centers for Medicare and Medicaid Services (CMS) interim final rules applicable to continuous glucose monitoring devices. A guidance memo, "Relaxation of VA Criteria for Use of Dispensation of Continuous Monitoring Devices," was sent to all VISN Directors and Chief Medical Officers on November 20, 2020 (Attachment 2).

Attachment 2

Department of Veterans Affairs

Memorandum

Date: November 20, 2020

From: Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11)

Subj: Relaxation of VA Criteria for Use of Dispensation of Continuous Monitoring Devices (VIEWS 03808764)

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
Veterans Health Administrations (VHA) Network Chief Medical Officers (CMOs) (10N1-23)

Thru: Assistant Under Secretary for Health for Operations (15) TC

1. The Centers for Medicare and Medicaid Services (CMS) issued an interim final rule that gives individuals and entities that provide services to Medicare, Medicaid, Basic Health Program, and Exchange beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the coronavirus disease 2019 (COVID-19), available at: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (see pages 158-159).

2. VHA leadership hereby agrees with CMS policy to relax the following clinical indications for all Veterans with COVID-19 with diabetes receiving care in VHA.

3. VHA will not enforce the current clinical indications restricting the type of diabetes that a beneficiary must have or relating to the demonstrated need for frequent blood glucose testing in order to permit COVID-19 infected patients with diabetes to receive therapeutic continuous glucose monitor. This discretion is intended to permit COVID-19 patients to more closely monitor their glucose levels given that they are at risk for unpredictable impacts of the infection on their glucose levels and health. The use of therapeutic continuous glucose monitors may allow patients to proactively treat their diabetes and prevent the need for hospital-based diabetic care. Practitioners will also have greater flexibility to allow more of their diabetic patients to better monitor their glucose and adjust insulin doses from home by using a therapeutic continuous glucose monitor. This enforcement discretion will only apply during the Public Health Emergency (PHE) for the COVID-19 pandemic.

Relaxation of VA Criteria for Use of Dispensation of Continuous Monitoring Devices (VIEWS 03808764)

4. Should you have further questions, please have a member of your staff contact Leonard Pogach, MD, MBA; National Program Director, Endocrinology and Diabetes, Specialty Care at 202-461-7153 or at leonard.pogach@va.gov.

Kameron Leigh Matthews, MD, JD, FAAFP

Questions for the Record from Senator Marsha Blackburn

Telemedicine Expansion

Question 1: **VHA's reopening strategy indicates a strong prioritization of telemedicine services and continued expansion for virtual care modalities. Has VA adopted a roadmap with established milestones and time-bound goals for telemedicine expansion?**

VA Response: Pre-COVID-19, VA had a Connected Care strategic plan in place. VA currently is developing a new five-year plan that will incorporate the exponential digital expansion VA achieved during the pandemic and the transformation trajectory VA is setting for the future (completion date pending).

Question 2: **In what specific ways is VA coordinating to manage resources, meet objectives and mitigate risks?**

VA Response: In association with the development of its five-year strategic plan, VA also is developing operating plan metrics and milestones for the organization that will be tracked in a national online database.

Question 3: **How is VA measuring success as it expands telemedicine services?**

VA Response: VA tracks and monitors the volume of virtual care encounters across all modalities over time. VA also tracks Veteran satisfaction and provider satisfaction with telehealth. Additionally, VA partners with evaluation and research teams to identify more specific clinical insights from its services.

Question 4: **In what ways is VA capturing the Veteran and provider experience through telemedicine to ensure high quality of care?**

VA Response: VA uses seven different surveys to capture Veteran experience data for multiple aspects and types of telehealth Veteran appointments. VA captures survey information for aspects of scheduling and then completion of the appointment for all three telehealth modalities (synchronous, asynchronous and remote patient monitoring). Since January 2020, VA sent over 290,000 surveys and received approximately 50,000 responses (17% response rate). Note: These figures include all three modalities. Additionally, VA uses similar methodology to solicit feedback from providers who use telehealth for patient care. VA sends surveys to novice and experienced telehealth providers about their experience providing telehealth services. Since January 2020, VA sent approximately 32,000 surveys and received approximately 3,500 responses (11% response rate).

Telecommunications Agreements

Question 5: **The CARES Act includes a provision that allows VA to enter into short-term agreements with telecommunications providers to expand services for isolated Veterans. In April, I signed a bi-partisan letter with my fellow committee members encouraging the VA to fully implement this necessary authority, which took VA several months to initiate action.**

Question 6: **How many telecom partnerships has VA entered into using the CARES authority to date?**

VA Response: T-Mobile, Verizon, Sprint (now owned by T-Mobile) and SafeLink by TracFone are supporting Veterans' connections through video and VA Video Connect (VVC) by zero rating the VVC application. Zero rating prevents Veterans from being charged for data while using VVC on the carrier's network.

For Veterans living in broadband-poor areas, the ATLAS pilot offers Veterans the option of private telehealth appointment space equipped with high-speed internet and telehealth-compatible technology. These stations allow Veterans to access their VA care more easily, thus reducing the need for travel or for home broadband. In response to local interest from telecommunications partners in Kansas following passage of the CARES Act, VA stood up a Tiger Team. The Tiger Team identified non-VA locations in Kansas that might be a good fit for ATLAS, which resulted in identification of Golden Belt Telephone Company whose intent is to partner with the Heart of Kansas healthcare facility on an ATLAS location.

Question 7: **What barriers exist when collaborating with commercial partners that have identified solutions for the VA?**

VA Response: The problem posed by the digital divide is broad in scope. Numerous telecommunications companies serve, or potentially serve, the Veterans who need internet connections and technical support. Attempting to develop contractual relationships with numerous telecommunication companies on behalf of Veterans poses workforce, logistical, contracting and legal barriers for the VA that the CARES Act does not solve. As an alternate approach, an internet benefit could go directly to Veterans through the Federal Communication Commission's LifeLine program or a new offering. Placing choice and control in the hands of the Veteran would alleviate the logistical challenges of contracting with numerous companies, enable the Veteran to own and control their service and incentivize internet service providers to compete for the Veteran market.

VistA

Question 8: **I am aware that due to the COVID-19 response, the EHRM process has largely been put on hold. When do you anticipate the VA to establish new implementation timelines for the Cerner Genesis EHR rollout?**

VA Response: Due to COVID-19, The Office of Electronic Health Record Modernization (OEHRM) immediately shifted to a non-intrusive posture while continuing to advance its mission to the greatest extent possible without compromising the health and safety of Veterans and clinicians.

Based on COVID-19 impacts, VA revised the EHR modernization deployment strategy, while preserving the 10-year deployment timeline and the overall life cycle cost estimate. The revised deployment timeline was submitted to Congress on August 7, 2020. On August 21, 2020, VA successfully launched the new patient appointment tool at the VA Central Ohio Healthcare System. Additionally, on October 24, 2020, VA successfully launched the new EHR solution to Mann-Grandstaff VA Medical Center, West Consolidated Patient Center and the associated Community Based Outpatient Clinics.

Question 9: **As the transition from VistA to Gensis progresses, and given that about 30% of VistA (the non-EHR functionality) will continue to provide critical support across the VA, what is VA's current plan to manage the individual interoperability requirements at each site prior to go-live?**

VA Response: VA is committed to fulfilling the continued requirements of information assurance, development, enhancement and modernization of the Veterans Health Information Systems and Technology Architecture (VistA) to ensure the continuity of interoperability as the transition to Cerner Millennium progresses. As VA replaces VistA capabilities, VA will track milestones and coordinate with local leaders and technical experts. VA migrated and will continue to migrate data to support the transition. VA will not remove or inactivate VistA components until VA receives positive confirmation that no interoperability impacts will occur.

Cutover to Cerner Millennium Capability set 1.1 at the Mann-Grandstaff VA Medical Center occurred the weekend of October 25, 2020. VA originally scheduled the cutover for Spring 2020; however, it was delayed due to COVID-19. VA coordinated a site- specific plan across VA and successfully implemented it to support cutover activities in transitioning to the new Electronic Health Record solution. VA will pilot and validate the initial VistA Transition Plan based on lessons learned before finalizing and providing it to Committee staff.

VA OIT staff will continue to pilot and validate the initial VistA Transition Plan, which will be made available early January 2021.

Questions for the Record from Senator Mazie Hirono

Questions to Dr. Kevin Galpin, Executive Director of Telehealth Services, Veterans HealthAdministration

Question 1: **During the hearing you referenced a survey of Veterans' satisfaction in using telehealth. Could you please provide any data you have from that survey that is specific to Veterans in Hawaii, or in the VA Pacific Islands Health Care System more broadly?**

VA Response: Attached is the data from the survey mentioned during the hearing that is specific to Veterans in Hawaii (Attachment 3).

Question 2: **The MISSION Act included a provision I championed to allow VA providers to provide telehealth services to veterans across State lines.**

Question 2a: **How many providers have used that new authority?**

VA Response: From June 2018 through September 2020, 35,074 providers used that authority to provide care to Veterans across State lines.

Question 2b: **How many Veterans have been served under that new authority?**

VA Response: From June 2018 through September 2020, 118,483 Veterans have been served under that authority.

Question 3: **The VA is prohibited under law from providing care to Veterans in foreign countries, which includes the Freely Associated States.**

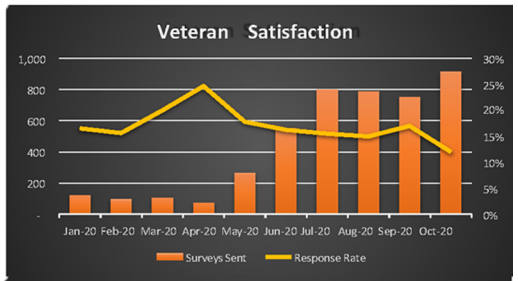
Question 3a: **How many Veterans each year travel from the Freely Associated States to the United States to access VA health care?**

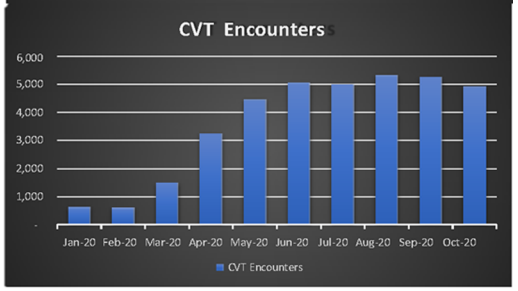
VA Response: VA does not track Veteran travel from the Freely Associated States to the United States for the purpose of accessing care. We can note in FY 2019, 94 VHA enrollees were from the Freely Associated States. Fewer than 10 of these individuals used VHA care in FY 2019.

Question 3b: **If there was a statutory change that would permit it, has VA considered the feasibility of providing telehealth to Veterans in the Freely Associated States? If so, what are additional barriers or challenges beyond the statutory prohibition?**

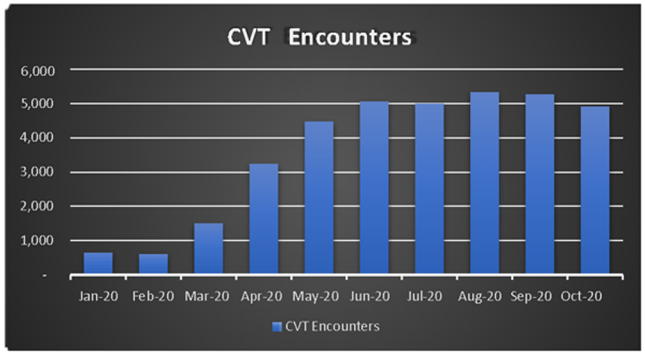
Attachment 3

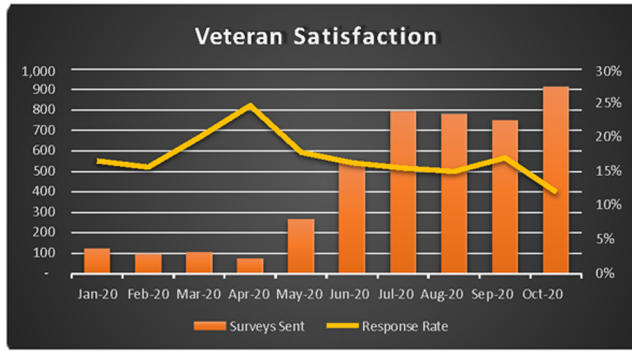
	Score % %4-5	Score % %4-5
Number of respondants	335	348
Telehealth Aggregated Trust	**Jan - Jul 2020**	**Aug - Oct 2020**
1. I trust Telehealth as part of my overall VA healthcare.	81%	80%
Telehealth Appointment Scheduling Survey		
1. I trust Telehealth as part of my overall VA healthcare.	82%	80%
2. I was given a choice between having my appointment in-person at a VA facility or through Telehealth.	57%	40%
3. I got my appointment on a date and time that worked for me.	93%	92%
4. When scheduling my appointment, I was treated with respect.	96%	96%
5. It was clear before my appointment what to expect.	81%	87%
Telehealth at the Clinic Appointment Survey		
1. I trust Telehealth as part of my overall VA healthcare.	90%	79%
2. After I checked in for my appointment, the clinic staff explained how the video Telehealth technology would work in a way that was easy to understand.	100%	100%
3. My provider explained things to me in a way that was easy to understand.	98%	93%
4. My provider listened to me during the appointment in a caring manner.	98%	93%
5. I was able to see the provider clearly by video.	92%	96%
6. I was able to hear the provider clearly by video.	92%	96%
7. The provider made me feel at ease by explaining every step they took during my appointment.	98%	93%
8. Overall, I am satisfied with the video Telehealth visit.	98%	93%
9. After my appointment, I was clear on what my next steps were.	98%	93%
10. Telehealth reduces the need to travel long distances in order to meet with my provider.	86%	79%
Telehealth at Home or Mobile Appointment Survey		
1. I trust Telehealth as part of my overall VA healthcare.	78%	81%
2. Connecting to my VA Video Connect appointment was easy.	88%	87%
3. The VA staff gave me information about connecting to my video Telehealth appointment.	89%	79%
4. My provider listened to me during the appointment in a caring manner.	96%	96%
5. My provider explained things to me in a way that was easy to understand.	96%	94%
6. After my appointment, I was clear about my next steps of care.	94%	93%
7. The provider made me feel at ease by explaining every step they took during my appointment.	93%	93%
8. Telehealth reduces the need to travel long distances in order to meet with my provider.	88%	85%
9. I was able to see the provider clearly by video.	85%	83%
10. I was able to hear the provider clearly by video.	85%	87%
11. Overall, I am satisfied with the video Telehealth visit.	81%	82%





	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
CVT Encounters	630	607	1,493	3,236	4,460	5,063	4,984	5,333	5,261	4,918
Surveys Sent	121	96	105	73	264	553	799	785	750	913
Respondents	20	15	21	18	47	90	124	117	125	106
Response Rate	17%	16%	20%	25%	18%	16%	16%	15%	17%	12%





VA Response: As you know, this is a highly complex issue, and VA is conducting an ongoing high- level bi-weekly Pacific Campaign Working Group Meeting to address concerns of Veterans in the Freely Associated States. The prospect of VA furnishing international telehealth services has been included in these and other internal VHA discussions; however, this topic poses a myriad of legal and clinical obstacles, even assuming there was new legal authority that would provide authority to VA providers to do this. It is alsolikely there are concerns not yet identified. For instance, VA providers must still be licensed in a state to practice in the VA health care system. As a result, this topic gets entangled with medical, nursing and other health care state licensure laws. Another keyconcern is if VA were to have such a statute permitting international telehealth, it is foreseeable that foreign countries or foreign providers would demand reciprocity in this regard and that is a significant matter for not only VA but also for the states and our country at large. Again, this is a highly complex topic, and we surmise this is why we donot see private sector providers doing this as part of their practices.

Questions for the Record from Senator Kyrsten Sinema

Questions for Dr. Kameron Matthews, Assistant Under Secretary for Health for Community Care, Veterans Health Administration

Question 1: **There are very pronounced challenges for Veterans experiencing homelessness to receive care, particularly during this pandemic when VA is largely relying on telehealth for non-urgent medical appointments. For these, the need for access to mobile devices and broadband can be a very real challenge to accessing telehealth. What steps has VA taken to ensure Veterans experiencing homelessness can receive the care they need during this time?**

VA Response: As VA homeless programs rapidly mobilize resources and strategies tomove Veterans into independent, permanent housing and hotels/motels to promote physical distancing, technology is vital to prevent these vulnerable Veterans from becoming socially isolated, which may trigger or exacerbate mental health symptoms. Technology also provides a mechanism to ensure Veterans remain engaged with homeless programs providers to monitor safety and wellbeing, participate in preventative health care, attend virtual groups and recovery programs and conduct virtual housing and job searches.

Recognizing the need for these technologies, VA is increasing capacity in its homeless programs by expanding telehealth and telecommunications capabilities. The CARES Act specifically requires VA to ensure telehealth capabilities are available during a public health emergency for case managers of, and homeless Veterans participating in, Housing and Urban Development–VA Supportive Housing (HUD-VASH). In response to this requirement, the VA's Office of Connected Care (OCC) and Homeless Programs Office (HPO) are collaborating to ensure HUD-VASH case management team members have the equipment necessary to provide telehealth services. An initial assessment of provider equipment needs resulted in procurement and distribution of over 2,800 pieces of telehealth technology equipment (iPads, webcams, speakers, monitors and headsets).

At the end of April 2020, VA obtained authority to purchase smartphones and data plans using appropriated funds for Veterans, and in June 2020, received $17 million in CARES Act funding to purchase approximately 50,000 disposable smartphones with unlimited data plans for Veterans in VA homeless programs. To date, HPO shipped approximately 20,000 phones to VA medical center homeless programs, with additional phones available to ship upon local completion of assessed need in Quarter 1 FY 2021. Additionally, OCC procured iPhones for Veterans participating in HUD-VASH and implemented the "Digital Divide Consult," a process for VA care teams to order these iPhones for shipment to Veterans. These iPhones are loaned devices managed and maintained by OCC.

Question 2: **As the COVID-19 pandemic continues, the impact of social isolation on the mental health of Veterans concerns me. With VA's public health approach to address Veteran suicide, how are you working with your Community Care partners to help identify and support at-risk Veterans?**

VA Response: Although there is no predictive analytic model data for Veterans who are not receiving VHA care, VA develops training materials and offers consultation services for community care providers. A few recent highlights include the VA Lethal Means Safety Training Course, which the VA recently updated, and it is now available in VA's Talent Management System and the external facing educational site, TRAIN. VA
S.A.V.E. suicide prevention training also is available for community providers. Further, VA also provides consultation services to any provider serving Veterans to assist with suicide risk management through the VA Suicide Risk Management Consultation Program. This consultation program also offers postvention consultation and support to any VA or community provider affected by a Veteran suicide. The following list gives several resources to provide support to our community provider colleagues as they provide services to Veterans across the Nation.

- Community Provider Toolkit: This toolkit supports the behavioral health and wellness of Veterans receiving services outside the VA health care system. More information is available at https://www.mentalhealth.va.gov/communityproviders/index.asp.

- Veteran Outreach Toolkit: The Veteran Outreach Toolkit is an online guide for people and organizations who are hosting events and interacting with Veterans. More information is available at https://www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf.

- S.A.V.E. Training Video: An online suicide prevention training video launched in collaboration with PsychArmor Institute. The training video is designed to help equip anyone who interacts with Veterans to demonstrate care, support and compassion when talking with a Veteran who could be at risk for suicide. The 25-minute training video is available for free at: https://psycharmor.org/courses/s-a-v-e/.

- VA's Social Media Safety Toolkit equips Veterans, their families, and their friends with the knowledge needed to respond to social media posts that indicate a Veteran may be having thoughts of suicide. You can download it for free at: www.mentalhealth.va.gov/suicide_prevention/docs/OMH-074-Suicide-Prevention-Social-Media-Toolkit-1-8_508.pdf.

- Uniting for Suicide Postvention: This website provides resources and support for everyone touched by suicide loss: https://www.mirecc.va.gov/visn19/postvention/.

- Short Takes on Suicide Prevention Podcast Series: This series by the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) interviews leaders in the field of suicide prevention to make their research available to everyone. Download the podcasts at https://www.mirecc.va.gov/visn19/education/media/.

VA shares other information with community providers on a variety of topics as a result of the pandemic. VA offers training for clinicians through VA's Extension for Community Healthcare Outcomes. These regular sessions include information on a variety of clinical topics. We also provide information to providers via the VA Community Care website[3] and on the Rural Health Information Hub website.[4] VA also offers free training to community providers, including training on posttraumatic stress disorder and military sexual trauma, via the Public Health Foundation's TRAIN website.[5]

Question 3: **VA has previously stated that this ramp up in telehealth is here to stay. As VA resumes normal pre-COVID-19 operations how is VA determining the appropriate mix of VA and community care in terms of telehealth and in-person care now and in the future?**

VA Response: VA continues to determine health care delivery and all its components (timing, location, modality and internal to VA or in the community) clinically at the time of care request and at the time of the care delivery. These decisions take into consideration an individual Veteran's preferences, eligibility criteria for community care, medical conditions and the specific need addressed during a visit. For example, VA prioritizes appointments that do not require a physical assessment for alternative modalities (telehealth, telephone and electronic consultation) over in person care, if accepted by the Veteran. Although facilities adapted to deliver safe in-person care, VA continues to implement specialty care expansion VA Video Connect (VVC) visits and telephone care to broaden available modalities for healthcare delivery. Given the continued growth of telehealth due to the COVID-19 pandemic, VHA plans to continue leveraging this care when appropriate and at the preference of the Veterans moving forward.

As VA resumes normal pre-COVID-19 operations, we are empowering Veterans to choose the type of care best for them. Referral Coordination Teams (RCT) clinically

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[3] "COVID-19 Guidance for Community Providers" VA website at https://www.va.gov/COMMUNITYCARE/providers/COVID-19_Guidance.asp.
[4] "Rural Healthcare Surge Readiness: Resources," Rural Health Information Hub website at https://www.ruralhealthinfo.org/healthcare-surge-readiness/topics/resources.
[5] TRAIN Learning Network website at https://www.train.org/main/welcome.

review referrals received for community care eligibility and appropriate care modalities, including e-consults, in-person, virtual care or telephone care. The RCT has a discussion with the Veteran to review all clinically appropriate internal and community care options and the Veteran chooses a preference of where and how to receive care. If a Veteran opts for community care, the Veteran may receive that care either in-person or via telehealth, depending on the community provider availability. In all cases, it is the Veteran's choice of how they are most comfortable receiving their care.

Question 3a: **How is the VA currently engaging Community Care partners to expand their telehealth capacity?**

VA Response: In the face of the national emergency, VA expanded the use of telehealth technology in the community provider networks through the Community Care Network (CCN) contract and collaborated with community providers nationwide to overcome barriers to delivering care. VA provided telehealth through authorized care referrals and through the urgent care/walk-in clinic benefit. VA is following the Centers for Medicare and Medicaid Services (CMS) guidance for reimbursement of telehealth visits to community providers. In CCN contracts in Regions 1-4, VA allows the third-party administrator to submit written Waiver Requests to VA to request the use of telehealth services to meet Network Access standards. In the CCN contract awarded to TriWest Health Care Alliance on October 1, 2020 for Region 5/Alaska, there is a requirement to provide telehealth services and consultations for Neuropsychology and Rheumatology at a minimum. Telehealth providers must be licensed in the State of Alaska, and the telehealth solution must comply with all Federal and State laws and regulations, including HIPAA. Telehealth services and consultations in Region 5 must be able to operate within the unique internet connectivity, broadband access, and geographic challenges presented in Alaska.

Question 4: **How is the VA currently leveraging other digital health solutions, like remote monitoring and digital therapeutics, to address chronic conditions? Does the VA have a comprehensive strategy on digital health in place?**

VA Response: For FY 2020, the Office of Connected Care's Remote Patient Monitoring-Home Telehealth (RPM-HT) provided over 140,000 Veterans across VA with an average daily census of approximately 70,000. At a national level, just over 60 percent of those Veterans enrolled were patients classified as Non-Institutional Care who are at risk for long term care placement and hospitalizations due to chronic, co-morbid diseases such as Heart Failure, Hypertension, Diabetes and Chronic Obstructive Pulmonary Disease as well as mental health monitoring.

The RPM-HT program applies care and case management principles to coordinate care using health informatics, disease management and technologies such as in-home and mobile remote patient monitoring, messaging and/or video technologies. The best candidates for these programs and activities are Veterans who are in post-acute care

settings, high-risk Veterans with chronic disease or Veterans at risk for institutional long-term care. The goal of Home Telehealth is to improve clinical outcomes and increase access to care while reducing complications, hospitalizations and clinic or emergency room visits. VA currently is planning for the re-solicitation of the current contract awarded to two vendors which ends February 2022. VA incorporated continued innovative strategies and technologies into this planning based on extensive market research and customer feedback.

Question 5: **The CARES Act included a provision for VA to enter into agreements or contracts with telecommunications companies to provide or subsidize fixed or mobile broadband to Veterans to provide tele-mental health for the duration of the public health emergency. Please provide a status update on these efforts and plans for future expansion, specifically to support rural, low- income, and other un- or underserved Veteran communities.**

VA Response: Through CARES Act funding, VA established a "Connected Phone" pilot for Veterans enrolled in Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), connecting these Veterans with a smartphone and the option of virtual care. The VA loans these smartphones to HUD-VASH Veterans and the Office of Connected Care manages them. In addition, the VA Office of Homeless Programs established a disposable phone program for homeless Veterans using CARES Act funding.

The Office of Connected Care also uses CARES Act funding to expand its loaned tablet program. Through this program, VA-loaned tablets issued to Veterans through the Digital Divide Consult are cellular enabled either through a T-Mobile or Verizon plan paid for by VA. The option of two mobile carriers permits optimization of coverage depending on the Veteran's geographic location. Currently, over 50,000 tablets are in circulation. As additional resources become available for subsidizing connectivity for Veterans, VA will modify the Digital Divide Consult to reflect the opportunities over time.

For Veterans living in broadband-poor areas, the ATLAS pilot offers Veterans the option of private telehealth appointment space equipped with high speed internet and telehealth-compatible technology. These stations allow Veterans to more easily access their VA care, thus reducing the need for travel or for home broadband. In response to local interest from telecommunications partners in Kansas following passage of the CARES Act, VA stood up a Tiger Team and identified non-VA locations in Kansas that might be a good fit for ATLAS. This effort resulted in identification of a site that is currently confirming space, equipment and staffing resources necessary to serve as an ATLAS site. Across the country, expansion of ATLAS sites is underway for FY 2021.

Questions for Dr. Kevin Galpin, Executive Director of Telehealth Services, Veterans Health Administration

Question 1: **How is VA engaging caregivers virtually during this time, to ensure they remain included given their vital importance to the health of the Veteran?**

VA Response: VA Social Workers focus on assisting Veterans, their families and caregivers in resolving Social Determinants of Health (SDOH) challenges to health and well-being. In response to the pandemic, VA Social Workers increased the use of approved virtual platforms, including VA Video Connect (VVC), to Veterans and caregivers for deficits in key social determinant of health domains and provide social work interventions including psychosocial support, therapeutic interventions and referrals to VA and community-based resources. Social Workers also use technology to conduct clinical video interventions including caregiver support groups, individual and family therapy, advanced care planning and case management.

Virtual contact with caregivers and Veterans has been a smooth transition for the Caregiver Support Program (CSP), because CSP has been using virtual modes of communication for some time, for example, telephone (individual and group support/education), VVC, My HealtheVet (MHV), conventional mail and newsletters. Up to October 1, 2020, VA contacted caregivers in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) at least quarterly, and more often as needed. VA allowed these contacts in person, by VVC or by phone; however, with COVID-19, most visits are by phone or VVC.

Telephone use for support groups occurs locally and nationally. The Caregiver Support Line (CSL) hosts monthly education group sessions by telephone. Caregivers may make comments and ask questions on these calls. Another resource is the Peer Support Mentoring (PSM) Program. PSM strengthens relationships between caregivers, provides an opportunity for networking and empowers caregivers to help one another. VA encouraged PSM as an in-person program, but it transitioned well to become a virtual program. In addition, the PSM Program Manager holds and hosts a telephone support group quarterly with different topics to support Spanish-speaking caregivers.

Several other educational programs are available virtually, as well as information offered on the website https://www.caregiver.va.gov/. Caregivers also may call the CSL at 1-855-260-3274 and speak with a clinical social worker.

Question 2: **What feedback are you collecting from caregivers to understand their participation and experience with VA telehealth, and how are you using those data to improve telehealth protocols to be inclusive to caregivers?**

VA Response: The Office of Connected Care Remote Patient Monitoring-Home Telehealth (RPM-HT) program has a long history of supporting caregivers in the home.

Frequent assessments using the Caregiver Burden Scale, documented in the Veteran's electronic Medical record, assists the RPM-HT Care Coordinator in determining specific caregiver needs and suitable interventions to support the Veteran and caregiver. RPM-HT discussed development of a specific caregiver experience survey tool and it is in process for these programs.

RPM-HT established four workgroups (training, mentoring, partnerships and marketing) to properly publicize and educate Caregiver Support Program staff and caregivers on use of VA Video Connect (VVC). RPM-HT held two national virtual trainings with 1,300 attendees logged on. RPM-HT selected Caregiver Support Program staff from each VISN and trained then on the use of VVC to provide support to caregivers. RPM-HT held weekly technical support calls and initiated a "buddy system" to mentor other Caregiver Support Program staff as the program rolled out nationally to support and care for our Veterans' caregivers.

From April 1, 2020 to September 30, 2020, 519 Caregiver Support Coordinators or other caregiver support staff used VVC for at least one caregiver encounter. In FY 2020, Q2-Q4, 12,398 caregiver encounters completed via VVC, of which 10,197 were unique.

Question 3: **What is VA's capacity to continue a robust telehealth option in the future? Do you need any additional authorities from Congress to do so?**

VA Response: VA has tremendous potential to maintain a robust telehealth program for Veterans. However, there is one area where authorizing legislation would help VA better serve Veterans through telehealth.

VA MISSION Act of 2018, Section 151, "Licensure of Health Care Professionals of the Department of Veterans Affairs Providing Treatment via Telemedicine," enables VA-employed healthcare professionals with an active, current, full, and unrestricted license, registration, or certification in any State to care for Veterans regardless of the location of the health care professional or the Veteran, if the covered health care professional is using telemedicine to provide treatment to the individual. The authority provided within Section 151 has been the foundation for the VA "Anywhere to Anywhere" telehealth initiative and has proven critical to its recent telehealth success.

However, the current definition of covered health care professionals in the VA MISSION Act does not include qualified VA healthcare professionals without an active, current, full and unrestricted license, registration or certification in a State. Examples of such health care professionals are trainees, mental health professionals working under supervision of another VA health care professional or health care professionals who don't require a State-based credential. Expanding the definition of health care professionals in the MISSION Act would enable VA to use all its health care professionals to deliver, or help deliver, telehealth services.

VA testified on this topic before the House Veterans' Affairs Health Subcommittee on July 23, 2020, in the context of commentary on H.R. 3228:

> **The proposed legislation would expand the definition of Covered Health Care Professional to authorize a health professional trainee to participate in telemedicine in accordance with 38 U.S.C. § 1730C when working under the clinical supervision of a VA health care professional licensed, registered, or certified in a State.**
>
> **VA supports the bill as written because it would enhance services to Veterans and support VA's critical education mission by clearly authorizing the participation of health care professional trainees in telehealth, irrespective of location in a State, if under appropriate supervision by a VA employed health care professional who is licensed, registered, or certified in a State. However, we would like the Committee to consider further expanding the definition of health care professional to include health care professionals who meet VA qualification standards but are not licensed, registered, or certified in a State and health care professionals who are employed by VA and working under the clinical supervision of a fully qualified health care professional and who are required to obtain a full and unrestricted licensure, registration, or certification, or meet qualification standards within a specified time frame. Expanding the definition of health care professional in this way would enable VA to integrate telehealth into the capabilities of all VA health care professionals, positioning VA to best leverage all its clinical assets in support of access and Veterans' care. We would be happy to work with the Committee to provide technical assistance.**

Question 4: **What demographic analysis is VA doing to understand telehealth usage across different communities both pre- and post-COVID?**

VA Response: VA reviews and analyzes telehealth workload activity. This analysis includes a review based on age, gender, race and rurality demographics, pre- and post COVID-19. The VA also initiated Health Services Research and Development Service (HSRD) efforts to complete a more robust review and analysis of minority Veteran data.

Question 4a: **What is the rate of usage among women Veterans, minority populations, Tribal communities and rural communities as compared to other populations and how has it been changing over time?**

VA Response:

Women Veterans: In the figure below, for FY 2020, the percentage of female Veterans receiving telehealth started to exceed the percentage of female Veterans using VHA as a whole and continues to grow.

	EOFY 19 National %	EOFY 19 % in CVT & SFT [6]	FY 20 National % thru May	FY 20 thru May % in CVT & SFT	EOFY 20 National %	EOFY 20 % in CVT & SFT
Female	11.80%	10.04%	11.00%	13.40%	11.46%	13.67%

Other Populations:

	EOFY 19 National %	EOFY 19 % in CVT & SFT	FY 20 National % thru May	FY 20 thru May % in CVT & SFT	EOFY 20 National %	EOFY 20 % in CVT & SFT
American Indian or Alaskan Native	0.76%	0.96%	0.78%	0.91%	0.78%	0.82%
Asian	1.09%	0.83%	1.13%	1.15%	1.14%	1.28%
African American	16.50%	15.50%	17.27%	18.09%	17.03%	19.44%
Declined to answer or unknown	11.14%	5.84%	9.20%	6.45%	9.97%	6.94%
Multiple	0.85%	0.95%	0.89%	1.07%	0.89%	1.08%
Native Hawaiian or other Pacific Islander	0.85%	0.90%	0.87%	0.98%	0.88%	0.98%
White	68.75%	75.00%	69.85%	71.35%	69.30%	69.46%

[6] Synchronous Clinical Video Telehealth **(CVT)** uses real-time, interactive videoconferencing to enable providers to assess, treat, and provide care to patients remotely. Synchronous Telehealth connects a provider with a patient at a different location, whether that is in a clinic, in the hospital, or in the patient's home or another non-VA location. Asynchronous Store and Forward Telehealth **(SFT)** care is provided through a clinical consultation and enables providers to communicate about a patient encounter through a defined information technology platform. This platform enables documentation of the patient encounter and associated clinical evaluation within the patient record.

Rural: During COVID, more Veterans living in urban areas began using telehealth and this cohort became a growing proportion of the total Veterans using telehealth. Although the proportion of rural telehealth thus inevitably decreased, the actual volume greatly increased in number of rural Veteran users and the number of rural telehealth visits.

Rural, Highly Rural and Insular Island					
FY 19 National %	EOFY 19 % in CVT & SFT	FY 20 National % thru May	FY 20 thru May % in CVT & SFT	EOFY 20 National %	EOFY 20 % in CVT & SFT
32.90%	45%	33.85%	35.92%	33.56%	32.14%

Question 4b: **How are you using these data to inform (1) outreach to populations who can most benefit from telehealth, (2) expansion of telehealth services and (3) actions to decrease barriers to access?**

VA Response: At the onset of the COVID-19 pandemic, the Office of Connected Care (OCC) initiated outreach efforts to promote the availability and expansion of Veteran access to care through virtual technologies. OCC raised Veterans' awareness for accessing telehealth services through a wide range of communication tools that include website postings, webinars, published news articles, media interviews and blog and social media postings. Here are a few examples:

- Updated the "What's New" section with virtual tool resources for Veterans: https://www.connectedcare.va.gov/whats-new/technology/protect-yourself-covid-19-va-virtual-tools.

- Contributed content to VA.gov Coronavirus FAQs which include information on telehealth and other virtual tools: https://www.va.gov/coronavirus-veteran-frequently-asked-questions/.

- Shared articles and content on My HealtheVet, VA's Veteran portal, with over 5 million registered users. Informative articles were posted 23 times from March - October 2020, on a range of COVID-19 topics. Examples of these articles are:

    - Access VA Care from Home (March 23, 2020) and updated (August 25, 2020).

    - Coronavirus: What Veterans Need to Know (March 25, 2020).

- Appointments: Should You Reschedule? (October 6, 2020).
- Mask Up Winter is Coming (October 20, 2020).

- Published newsletter articles:
  - All My HealtheVet articles were promoted in the My HealtheVet newsletter (distributed to almost 1million subscribers biweekly in March - October issues).
  - Vet Resources newsletter included VA Video Connect (VVC) article and link to public service announcements (distributed to approximately 8 million subscribers).

- The OCC leadership hosted or participated in several webinars, for example: Telehealth webinar with the Elizabeth Dole Foundation and Philips (April 16, 2020) was open to Veterans and caregivers.

- Other communication vehicles:
  - Posted external Veteran-facing blogs.
  - Numerous Twitter social media postings from March to October 2020.
  - Developed information flyers in support of COVID-19 management for Veterans.

- Actions to decrease barriers to access:
  - In accordance with the VA MISSION Act of 2018, Section 401, the Office of Veterans Access to Care developed an underserved program for Veteran Integrated Service Networks (VISN) to identify and develop plans to address health care in underserved areas with respect to primary care and mental health care. The Office of Veterans Access to Care created the program in collaboration with VISN leadership, VA Central Office leadership, Health Resources Services Administration (HRSA), VA Health Services Researchers and national leaders in mental health, primary care and rural health.
  - Based upon an understanding of HRSA's definition of "underserved" and feedback from stakeholders, VA established criteria and created a statistical model to identify underserved facilities in primary care and mental health services. Identification of underserved areas is not limited to rural areas but can also classify urban and metropolitan areas as underserved. The criteria to designate VA Medical Centers, ambulatory care facilities and Community

Based Outpatient Clinics of the VA as underserved facilities is reviewed and updated annually based on feedback from stakeholders. Each year, VA submits a Congressionally Mandated Report (CMR) containing the criteria to identify underserved facilities and action plans detailing the strategies that underserved medical centers and networks will use to improve access to care at their facilities.

- To reach out to underserved communities, VA is taking strides to bridge the digital divide for Veterans who lack the technology or broadband internet connectivity required to participate in VA telehealth. VA currently distributed more than 50,000 cellular-enabled tablets to Veterans across the country, and VA partnered with major wireless carriers including Verizon, T-Mobile, SafeLink by Tracfone and Sprint (now owned by T-Mobile) to support Veterans' access to VA telehealth services.

- VA also implemented a clinical resource hub in each VISN, staffed by primary care and mental health care providers who can deliver care remotely via telehealth to underserved facilities and communities.

Question 4c: **Women Veterans who may not feel comfortable accessing care at VA facilities might be more willing to receive that care via a telehealth environment. What research are you conducting to assess whether women Veterans prefer telehealth appointments to in-person care and how are you incorporating that research into your telehealth expansion plans?**

VA Response: A survey, designed by the Veterans Experience Office in partnership with VA Telehealth Services to inquire about Veteran experiences during the COVID-19 pandemic, asked Veterans about their appointment preferences (video to home, phone or in-person). For Veterans completing video to home visits during the COVID-19 pandemic, 36.2% of female Veterans preferred video telehealth compared to 27.7% male Veterans.

To better understand outcomes and preferences when it comes to care delivered virtually, VA is funding several research projects that VA's HSR&D teams will conduct to inform a deeper understanding of the users and non-users of telehealth, Veteran experiences including those of women Veterans, as well as ongoing development of virtual care tools, implementation and expansion of virtual care at VA.

Questions for Dr. Thomas Klobucar, Executive Director, Office of Rural Health, Veterans Health Administration

Question 1: **In response to my question regarding how VA is addressing concerns Veterans may have about telehealth appointments, you outlined several initiatives to survey Veterans who have engaged with telehealth services in some form to receive feedback. What data are you collecting from Veterans who have engaged with telehealth services to better understand perceived or actual barriers to using telehealth for this population?**

VA Response: Using the VSignals reporting structure, VA can break down Veteran satisfaction by rurality (Attachment 4). The attached document contains Veteran satisfaction by rural and highly rural. VA can compare this data to overall Veteran satisfaction scores.

Attachment 4

Data from FY 2020

	Score %
Non-Telehealth Provider	**%4-5**
1. It is clear to me what technology I would need to conduct Telehealth for my specialty. (Ease/Simplicity)	51.1
2. I feel as though Telehealth would be compatible with my specialty. (Ease/Simplicity)	58.4
3. I anticipate Telehealth equipment and software would be easy to use. (Ease/Simplicity)	58.1
4. Educational resources (e.g., TMS training and SharePoint) regarding Telehealth are easily accessible. (Ease/Simplicity)	50.2
5. Telehealth would allow me to more efficiently provide care to my patients. (Efficiency/Speed)	52.1
6. My local leadership encourages the use of Telehealth. (Employee Helpfulness)	51.5
7. I can provide quality care through Telehealth services. (Quality)	53.0
8. I trust the VA Telehealth Services to support me in providing successful Telehealth care to my patients. (Confidence/Trust)	53.9
Telehealth Awareness	
1. It is clear to me what technology I would need to conduct Telehealth for my specialty. (Ease/Simplicity)	70.1
2. I feel as though Telehealth would be compatible with my specialty. (Ease/Simplicity)	67.3
3. I anticipate Telehealth equipment and software would be easy to use. (Ease/Simplicity)	62.2
4. Educational resources (e.g., TMS training and SharePoint) regarding Telehealth are easily accessible. (Ease/Simplicity)	63.9
5. Telehealth would allow me to more efficiently provide care to my patients. (Efficiency/Speed)	55.9
6. My local leadership encourages the use of Telehealth. (Employee Helpfulness)	71.5
7. I can provide quality care through Telehealth services. (Quality)	60.5
8. I trust the VA Telehealth Services to support me in providing successful Telehealth care to my patients. (Confidence/Trust)	60.6
Recent Telehealth Adoption - CVT	
1. I received access to my Telehealth equipment and software in a timely manner. (Efficiency/Speed)	75.3
2. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Clinical Video Telehealth (CVT). (Ease/Simplicity)	73.1
3. I can provide quality care through Clinical Video Telehealth (CVT) services. (Quality)	71.0
4. The VA National Telehealth Office and local leadership are transparent with me about how and when I access Telehealth technology. (Equity/Transparency)	56.7
5. Overall, I am satisfied with my Clinical Video Telehealth (CVT) experience. (Satisfaction)	60.6
6. I trust the VA Telehealth Services to support me in providing successful Clinical Video Telehealth (CVT) care to my patients. (Confidence/Trust)	64.2
Recent Telehealth Adoption - HT	
1. I received access to my Telehealth equipment and software in a timely manner. (Efficiency/Speed)	68.8
2. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Home Telehealth and Telemonitoring (HT). (Ease/Simplicity)	71.9
3. I can provide quality care through Home Telehealth and Telemonitoring (HT) services. (Quality)	71.9
4. The VA National Telehealth Office and local leadership are transparent with me about how and when I access Telehealth technology. (Equity/Transparency)	59.4
5. Overall, I am satisfied with my Home Telehealth and Telemonitoring (HT) experience. (Satisfaction)	65.6
6. I trust the VA Telehealth Services to support me in providing successful Home Telehealth and Telemonitoring (HT) care to my patients. (Confidence/Trust)	68.8
Recent Telehealth Adoption - SFT	
1. I received access to my Telehealth equipment and software in a timely manner. (Efficiency/Speed)	55.4
2. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Store and Forward Telehealth (SFT). (Ease/Simplicity)	55.4
3. I can provide quality care through Store and Forward Telehealth (SFT) services. (Quality)	57.8
4. The VA National Telehealth Office and local leadership are transparent with me about how and when I access Telehealth technology. (Equity/Transparency)	49.4
5. Overall, I am satisfied with my Store and Forward Telehealth (SFT) experience. (Satisfaction)	48.2
6. I trust the VA Telehealth Services to support me in providing successful Store and Forward Telehealth (SFT) care to my patients. (Confidence/Trust)	54.2
Continued Telehealth Exposure - CVT	
1. During my last three to four Clinical Video Telehealth (CVT) appointments, I have had good internet connection. (Efficiency/Speed)	70.1
2. I am able to visually see the Veteran clearly while conducting Clinical Video Telehealth (CVT) appointments. (Efficiency/Speed)	72.9
3. I am able to hear the Veteran clearly while conducting Clinical Video Telehealth (CVT) appointments. (Efficiency/Speed)	67.1
4. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Clinical Video Telehealth (CVT). (Ease/Simplicity)	79.2
5. I can provide quality care through Clinical Video Telehealth (CVT) services. (Quality)	80.4
6. The VA National Telehealth Office and local leadership are transparent with me about how and when I can access Telehealth technology. (Equity/Transparency)	66.5
7. Overall, I am satisfied with my Clinical Video Telehealth (CVT) experience. (Satisfaction)	69.3
8. I trust the VA Telehealth Services to support me in providing successful Clinical Video Telehealth (CVT) care to my patients. (Confidence/Trust)	70.5
Continued Telehealth Exposure - HT	
1. During my last three to four Home Telehealth and Telemonitoring (HT) appointments, I have had good internet connection. (Efficiency/Speed)	88.3
2. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Home Telehealth and Telemonitoring (HT). (Ease/Simplicity)	83.0
3. I can provide quality care through Home Telehealth and Telemonitoring (HT) services. (Quality)	93.1
4. The VA National Telehealth Office and local leadership are transparent with me about how and when I can access Telehealth technology. (Equity/Transparency)	77.3
5. Overall, I am satisfied with my Home Telehealth and Telemonitoring (HT) experience. (Satisfaction)	83.8
6. I trust the VA Telehealth Services to support me in providing successful Home Telehealth and Telemonitoring (HT) care to my patients. (Confidence/Trust)	81.0
Continued Telehealth Exposure - SFT	
1. During my last three to four Store and Forward Telehealth (SFT) appointments, I have had good internet connection. (Efficiency/Speed)	81.6
2. I feel confident accessing and navigating educational resources (e.g., TMS training and SharePoint) regarding Store and Forward Telehealth (SFT). (Ease/Simplicity)	80.5
3. I can provide quality care through Store and Forward Telehealth (SFT) services. (Quality)	87.6
4. The VA National Telehealth Office and local leadership are transparent with me about how and when I can access Telehealth technology. (Equity/Transparency)	68.5
5. Overall, I am satisfied with my Store and Forward Telehealth (SFT) experience. (Satisfaction)	81.6
6. I trust the VA Telehealth Services to support me in providing successful Store and Forward Telehealth (SFT) care to my patients. (Confidence/Trust)	77.9

SVAC 7.29.2020
Telehealth Hearing Deliverables

1. **HIRONO:** I was just listening to you, Dr. Galpin, talking about surveying veterans. Have you surveyed any veterans in Hawaii, as to how they feel about telehealth?
GALPIN: I am fairly positive we have. We distribute surveys after our video visits. I don't have the breakdown here, but we can provide a breakdown, I think it's by visiting a facility. So, we can certainly get that information to you.

   Response: The attached spreadsheet contains the survey breakdown for Veterans served in Hawaii for January – July 2020.

Video Telehealth Visits to Home or Offsite Location			
State or Territory	FEB – FY20	JUL– FY20	% Increase
All	41,425	657,545	1487%
AK	27	882	3167%
AL	941	8,061	757%
AR	173	5,238	2928%
AS	1	48	4700%
AZ	1,161	22,633	1849%
CA	3,569	61,819	1632%
CO	754	6,622	778%
CT	247	4,310	1645%
DC	542	4,224	679%
DE	193	2,209	1045%
FL	3,350	91,425	2629%
GA	1,535	30,318	1875%
GU	56	641	1045%
HI	550	4,201	664%
IA	664	4,842	629%
ID	266	2,173	717%
IL	951	10,373	991%
IN	725	8,174	1027%
KS	254	5,388	2021%
KY	814	7,408	810%
LA	228	5,081	2129%
MA	677	13,832	1943%
MD	542	5,501	915%
ME	293	2,590	784%
MI	1,153	12,974	1025%
MN	616	7,506	1119%
MO	600	12,584	1997%
MP			

MS	92	3,724	3948%
MT	143	977	583%
NC	1,031	16,310	1482%
ND	189	1,028	444%
NE	155	2,594	1574%
NH	99	2,589	2515%
NJ	432	8,299	1821%
NM	123	3,391	2657%

2. **CASSIDY:** Then let me ask you one more question. Dr. Galpin, one more thing. I'm a gastroenterologist, I think I knew at one time the VA required somebody to drive in to be consented; even if they lived 100 miles away, they have to drive in, get consented, return home, and come back for the colonoscopy. It seemed veryimpractical as anyone who's taken a colonoscopy prep can imagine. So, the question is, will VA regulations allow people to be consented for a procedure like colonoscopies remotely by--by a telehealth visit, as opposed to having to drive in?
GALPIN: I believe the answer is yes to that. But I need to check back to make sure I'm being consistent with the regulation, but yes, I believe the answer is yes to that.
CASSIDY: Please let us know that. Okay, thank you.

VHA Response: The National Center for Ethics in Health Care has developed and approved an asynchronous method of obtaining consent. The process allows the informed consent process to be completed in circumstances when the patient (or surrogate) and practitioner cannot be physically together but are still able to directly communicate. For example, the asynchronous signature capability enables the consent form to be signed at different locations (VAMC, CBOC) following an informed consent discussion held via telephone or video. Attached is the Frequently Asked Questions - iMedConsent Asynchronous

National Center for ETHICS in Health Care

December 17, 2014

Frequently Asked Questions

iMedConsent™ Asynchronous Signature

1. **What is iMedConsent™?**

iMedConsent™ is a software package that supports electronic access, completion, electronically captured signature, and storage of documents, such as informed consent forms and advance directives. VHA Handbook 1004.05, *iMedCONSENT™*, sets forth procedures related to the use of iMedConsent™.

VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, discusses the goals, scope, and key concepts related to patients' informed consent for clinical treatments and procedures and the related responsibilities of VHA staff. Handbook 1004.01 mandates the use of the iMedConsent™ software program to document the informed consent process, except in specific circumstances.

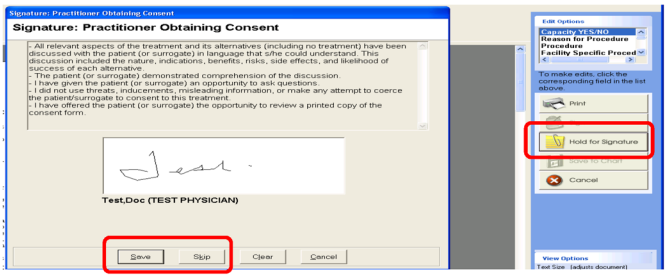
2. **What is the relevant patch information in iMedConsent™ that includes asynchronous signature? (For Clinical Application Coordinators)**
   - Patch Name: Nabokov
   - Patch Number: 3.837.000.035
   - Release Date: December 5, 2014
   - Required Installation Date: January 30, 2015

3. **What is asynchronous signature?**
   The original version of iMedConsent™ did not allow consent forms to be saved in the patient's record, without both the practitioner's and patient's (or surrogate's) signature. This has meant that unless both people are available in the same place at the same time to sign the signature pad, the informed consent form cannot be completed. The new asynchronous signature capability allows for the signatures of the practitioner and the patient (or surrogate) to be obtained at different times and/or locations. Informed consent forms can be placed on hold, allowing signatures to be obtained separately.

4. **Why was the asynchronous signature capability designed?**
   The asynchronous signature capability was developed to reflect trends in telehealth, team care and clinical workflow that recognize informed consent as a process rather than an event. It was designed to allow more flexibility in the informed consent process and to make use of available communications technologies. Face-to-face interactions are not always possible when obtaining informed consent. The asynchronous signature capability allows for the informed consent process to be completed in circumstances when the patient (or surrogate) and practitioner cannot physically be together, but are still able to directly communicate. For example, the asynchronous signature capability enables the consent form to be signed at different locations (VAMC, CBOC) following an informed consent discussion held via telephone or video.

5. **How long can a consent form be placed on hold?**
   Consent forms can be placed on hold for signature in iMedConsent™ for 60 days. This timeframe was established to make sure that the informed consent discussion and signatures are close enough in time to reasonably ensure that the patient can remember the details of the informed consent discussion. Partially signed documents will be automatically deleted after 60 days if the second signature is not applied.

6. **Does the asynchronous signature capability change the iMedConsent™ process for obtaining informed consent?**
   The asynchronous signature capability does not change any processes in the consent wizards until the user clicks "sign." After the user clicks "sign," options are presented for signature by the practitioner and the patient (or surrogate). The practitioner may sign and "save" their signature or "skip" their signature. If "skip" signature is selected, a warning screen will be presented to the user that the signing practitioner must obtain consent from the patient (or surrogate) before signing the form.



7. **Can I edit the consent form after signing it?**
   If no signatures are "saved," users can edit the document. If a single signature has been "saved," users cannot edit the document unless the signature is removed. If both signatures have been "saved," users cannot edit the document.

8. **Is there a risk associated with leaving consent forms partially signed?**
   Yes. Partially signed or unsigned consent forms are placed on hold for additional signatures by clicking "Hold for Signature" in iMedConsent™. These documents then reside in "Documents to Sign" in iMedConsent™ until final signature, or for 60 days, whichever comes first. Placing documents on hold can be risky because there is the potential for practitioners to pull up and sign the incorrect consent form. It is important for practitioners to confirm that the document is the one they wish to sign before actually signing the document.

9. **Can aspects of the informed consent process be delegated to PACT members?**
   Yes. Providers can delegate aspects of the informed consent process to PACT members, as appropriate to the competency of the team member. Ultimately though, the practitioner is responsible for obtaining informed consent. Patient education can be conducted by PACT members, but the practitioner MUST be involved in the informed consent discussion to ensure that the patient understands and voluntarily accepts the recommended treatment before signing the consent form.

9. **Is the following an appropriate workflow for obtaining signature informed consent?** ***The LPN or RN completes the required education with the patient, builds the consent form and has the patient sign the consent form. The practitioner then signs the consent form.*** No. As stated in FAQ #8, PACT members, such as the LPN or RN, can be involved in the informed consent process, but ultimately the provider is responsible for obtaining informed consent. An appropriate workflow could entail the LPN or RN

providing patient education and building the consent form, followed by the practitioner having a conversation with the veteran to answer any remaining questions and ensuring the patient's understanding of the treatment. However, in such a workflow, neither the patient nor practitioner should sign the consent form until these steps have been completed.

Please check for updates to this FAQ document on the National Center for Ethics in Health Care's website: http://vaww.ethics.va.gov/activities/policy.asp.

For specific ethics concerns about informed consent, please contact your local Ethics Consultation Service. For questions regarding this FAQ document, please email vhaethics@va.gov or call 202-632-8457.

~end~

3. **BLUMENTHAL:** VA has provided some national statistics; specifically, that telehealth video visits have increased by 1132 percent, since February. Rising from about 11,238--thousand--700 (PH) appointments per week, between February and June 2020. Which is quite remarkable. Do you have statistics state by state, specifically for Connecticut?
GALPIN: I do not, with me, for this hearing.
BLUMENTHAL: Could you--could you provide them?
GALPIN: I believe we can get those state by state. I believe we can.

VHA Response: Nationally, video telehealth visits to home or an offsite location have increased by 1,487% between February and July of 2020. The visit numbers for February 2020 and July 2020 are listed by state in the table below along with each state's percent increase.

Video Telehealth Visits to Home or Offsite Location			
State or Territory	FEB – FY20	JUL– FY20	% Increase
All	41,425	657,545	1487%
AK	27	882	3167%
AL	941	8,061	757%
AR	173	5,238	2928%
AS	1	48	4700%
AZ	1,161	22,633	1849%
CA	3,569	61,819	1632%
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GA	1,535	30,318	1875%
GU	56	641	1045%
HI	550	4,201	664%
IA	664	4,842	629%

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KS	254	5,388	2021%
KY	814	7,408	810%
LA	228	5,081	2129%
MA	677	13,832	1943%
MD	542	5,501	915%
ME	293	2,590	784%
MI	1,153	12,974	1025%
MN	616	7,506	1119%
MO	600	12,584	1997%
MP			
MS	92	3,724	3948%
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NE	155	2,594	1574%
NH	99	2,589	2515%
NJ	432	8,299	1821%
NM	123	3,391	2657%
NV	713	11,751	1548%
NY	1,277	39,650	3005%
OH	1,149	28,189	2353%
OK	304	4,831	1489%
OR	572	8,584	1401%
PA	1,644	18,708	1038%
PH	0	0	
PR	64	13,123	20405%
RI	112	4,710	4105%
SC	1,836	25,068	1265%
SD	456	1,809	297%
TN	1,447	13,985	866%
TX	5,309	55,289	941%
UT	1,005	7,704	667%
VA	509	16,656	3172%
VI	0	25	
VT	103	1,726	1576%
WA	609	13,644	2140%
WI	780	7,834	904%
WV	282	3,110	1003%
WY	108	1,180	993%

4. **BLUMENTHAL**: How well is Connecticut doing, the VA in Connecticut is doing, in terms of telehealth?

GALPIN: I don't have state-specific information with us today.

VHA Response: The tables below list fiscal year 2019 and 2020 Telehealth activity for the Connecticut Health Care System.

Connecticut Health Care System (689)										
Unique Veterans receiving a portion of their care via Telehealth (Clinical Video, Store and Forward and Remote Patient Monitoring) from the Connecticut Health Care System and the year over year percent growth per month.										
Fiscal Year	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
FY19	1,320	1,628	1,879	2,170	2,438	2,697	2,993	3,308	3,584	3,908
FY20	1,373	1,757	2,074	2,439	2,767	3,606	4,661	5,655	6,776	7,779
% Growth	4.0%	7.9%	10.4%	12.4%	13.5%	33.7%	55.7%	70.9%	89.1%	99.1%

Connecticut Health Care System (689) **Performance Measures/Quality Indicators**	
Tele1 % -Telehealth Use Percentage of Veterans who received care in VA who received a portion of their care from telehealth during FY	14.30%
Tele2 % -Home Telehealth/Remote Patient Monitoring Percentage of Veterans who received care in VA who received a portion of their care from Home telehealth during FY	2.03%
Tele3 % -Clinical Video Telehealth Percentage of Veterans who received care in VA who received a portion of their care from Clinical Video telehealth during FY	12.11%
Tele4 % -Store & Forward Telehealth Percentage of Veterans who received care in VA who received a portion of their care from Store and Forward telehealth during FY	0.80%
Tele9 % -CVT to Offsite Patient Percentage of Veterans who received care in VA who received a portion of their care from Video to home or 8Offsite Location during FY	9.96%
Tele1- Telehealth Uniques (cumulative) Number of Veterans who receive care in VA who received a portion of their care from telehealth during FY	7,778
Tele2- HT/Remote Patient Monitoring Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Home telehealth during FY	1,106
Tele3- CVT Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Clinical Video telehealth during FY	6,587
Tele4- SFT Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Store and Forward telehealth during FY	433

Tele9- CVT to Offsite Patient Uniques (cumulative) Percentage of Veterans who received care in VA who received a portion of their care from Video to home or Offsite Location during FY	5,418

VHA Response: Nationally, video telehealth visits to home or an offsite location have increased by 1,487% between February and July of 2020. The visit numbers for February 2020 and July 2020 are listed by state in the table below along with each state's percent increase.

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DC	542	4,224	679%
DE	193	2,209	1045%
FL	3,350	91,425	2629%
GA	1,535	30,318	1875%
GU	56	641	1045%
HI	550	4,201	664%
IA	664	4,842	629%
ID	266	2,173	717%
IL	951	10,373	991%
IN	725	8,174	1027%
KS	254	5,388	2021%
KY	814	7,408	810%
LA	228	5,081	2129%
MA	677	13,832	1943%
MD	542	5,501	915%
ME	293	2,590	784%
MI	1,153	12,974	1025%
MN	616	7,506	1119%
MO	600	12,584	1997%
MP			
MS	92	3,724	3948%
MT	143	977	583%
NC	1,031	16,310	1482%
ND	189	1,028	444%
NE	155	2,594	1574%
NH	99	2,589	2515%
NJ	432	8,299	1821%
NM	123	3,391	2657%

NV	713	11,751	1548%
NY	1,277	39,650	3005%
OH	1,149	28,189	2353%
OK	304	4,831	1489%
OR	572	8,584	1401%
PA	1,644	18,708	1038%
PH	0	0	
PR	64	13,123	20405%
RI	112	4,710	4105%
SC	1,836	25,068	1265%
SD	456	1,809	297%
TN	1,447	13,985	866%
TX	5,309	55,289	941%
UT	1,005	7,704	667%
VA	509	16,656	3172%
VI	0	25	
VT	103	1,726	1576%
WA	609	13,644	2140%
WI	780	7,834	904%
WV	282	3,110	1003%
WY	108	1,180	993%

4. **BLUMENTHAL**: How well is Connecticut doing, the VA in Connecticut is doing, in terms of telehealth?
GALPIN: I don't have state-specific information with us today.

VHA Response: The tables below list fiscal year 2019 and 2020 Telehealth activity for the Connecticut Health Care System.

Connecticut Health Care System (689)										
Unique Veterans receiving a portion of their care via Telehealth (Clinical Video, Store and Forward and Remote Patient Monitoring) from the Connecticut Health Care System and the year over year percent growth per month.										
Fiscal Year	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
FY19	1,320	1,628	1,879	2,170	2,438	2,697	2,993	3,308	3,584	3,908
FY20	1,373	1,757	2,074	2,439	2,767	3,606	4,661	5,655	6,776	7,779
% Growth	4.0%	7.9%	10.4%	12.4%	13.5%	33.7%	55.7%	70.9%	89.1%	99.1%

Connecticut Health Care System (689) **Performance Measures/Quality Indicators**	
Tele1 % -Telehealth Use Percentage of Veterans who received care in VA who received a portion of their care from telehealth during FY	14.30%

Tele2 % -Home Telehealth/Remote Patient Monitoring Percentage of Veterans who received care in VA who received a portion of their care from Home telehealth during FY	2.03%
Tele3 % -Clinical Video Telehealth Percentage of Veterans who received care in VA who received a portion of their care from Clinical Video telehealth during FY	12.11%
Tele4 % -Store & Forward Telehealth Percentage of Veterans who received care in VA who received a portion of their care from Store and Forward telehealth during FY	0.80%
Tele9 % -CVT to Offsite Patient Percentage of Veterans who received care in VA who received a portion of their care from Video to home or 8Offsite Location during FY	9.96%
Tele1- Telehealth Uniques (cumulative) Number of Veterans who receive care in VA who received a portion of their care from telehealth during FY	7,778
Tele2- HT/Remote Patient Monitoring Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Home telehealth during FY	1,106
Tele3- CVT Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Clinical Video telehealth during FY	6,587
Tele4- SFT Uniques (cumulative) Number of Veterans who received care in VA who received a portion of their care from Store and Forward telehealth during FY	433
Tele9- CVT to Offsite Patient Uniques (cumulative) Percentage of Veterans who received care in VA who received a portion of their care from Video to home or Offsite Location during FY	5,418